PART XXIV FORMS

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Commonwealth of Virginia
Department of Social Services

APPLICATION FOR BENEFITS

GENERAL INFORMATION

With this application, you can apply for one or more of the following assistance programs. Refer to the fold-out page for instructions.

- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- Medicaid/Children's Health Insurance/FAMIS
- General Relief
- Emergency Assistance
- State and Local Hospitalization
- Auxiliary Grants
- Refugee Cash and Medical Assistance

Individuals who have a disability or who have difficulty with English may Receive extra help to make sure they get assistance or services they are Eligible to receive.

VERIFICATION AND USE OF INFORMATION

The information that you give may be matched against Federal, State and local records including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it is correct, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social service agency at the same time, and make required program changes.

The INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS) will also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of social security and Supplemental Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the Immigration and Naturalization Service (INS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

032-03-824/17 (5/04)

SPECIAL INFORMATION FOR FOOD STAMP APPLICANTS

You can apply for Food Stamps by leaving a completed Application for Benefits at the agency or by leaving a partially completed Application with at least your name, address, and signature, or by tearing off and leaving this half-sheet with your name, address, and signature. **You must complete the rest of this Application before your eligibility can be determined.**

You must also be interviewed. Under certain hardships, you can be interviewed by telephone. You may turn in your application before you are interviewed. This is important because if you are eligible for the month in which you apply, your food stamp amount will be based on the date you actually turn in your application.

EXPEDITED SERVICE FOR FOOD STAMPS

Your household may qualify for Expedited Service and receive food stamps within 7 days if you are eligible and if your gross monthly income is less than $150 and liquid resources are $100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farm worker household with little or no income and resources. **GIVE THE INFORMATION BELOW, SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions	$_____
Total cash, money in checking/savings accounts, CDs	$_____
Total rent or mortgage for this month	$_____
Total utility expenses for this month Do no count amounts due for previous months. Count only the basic telephone service cost.	$_____
Is anyone in your household a migrant or seasonal farm worker	YES ( ) NO ( )

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

AGENCY USE ONLY

CASE NAME		
CASE NUMBER		
LOCALITY	WORKER	DATE

EXPEDITED SERVICE DETERMINATION

Income less than $150 and Resources $100 or less — YES ( ) NO ( )

Income plus resources less than shelter bills — YES ( ) NO ( )

For migrants or seasonal farm workers:

Resources $100 or less, and in next 10 days $25 or less is expected from new income:

OR

Resources $100 or less, and no income is expected from a terminated source for the rest of this month or next month. — YES ( ) NO ( )

EXPEDITE IF YES TO ANY OF THE ABOVE.

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required. However, if you decided not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be arrested and prosecuted for fraud.

VIRGINIA SOCIAL SERVICES BENEFIT PROGRAMS BOOKLET

This booklet contains information about the programs available at your local social services agency plus other very important information you should know, including your responsibilities. READ THIS BOOKLET CAREFULLY. Refer to the APPEALS Section if you have a complaint about an action taken on your case.

COMPLETING THE APPLICATION

If you need help completing this Application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 8 people are living in your home and you need more space to list everyone, tell the agency you need extra pages. If you want Medicaid and you are under 18 years of age, your parent or legal guardian must sign the application.

FILING THE APPLICATION

You may turn in a partially completed Application which contains at least your name, address, and signature (or the signature of your authorized representative), **but you must complete the rest of this Application before your eligibility can be determined.** For some programs, you must also be interviewed, but you may turn in your Application before your interview. You may turn in your Application any time during office hours the same day as you contact your local agency. You have the right to turn in your Application even if it looks like you may not be eligible for benefits.

YOUR FOOD STAMP RIGHTS

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs and disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

APPLICATION FOR BENEFITS

AGENCY USE ONLY				
CASE NAME	CASE NUMBER	PROGRAM	WORKER CASELOAD	DATE REC'D.
DATE OF SERVICE REFERRAL	DATE OF INTERVIEW	LOCALITY		

1. I am requesting: ( ) Food Stamps ( ) TANF ( ) Medicaid/Children's Health Insurance/FAMIS ( ) Other Financial or Medical Assistance
( ) I understand that an application for TANF is also an application for Food Stamps and I do not wish to apply for Food Stamps.

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	PHONE NUMBER (HOME/MESSAGES) (WORK)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)		DIRECTIONS TO HOME
MAILING ADDRESS (IF DIFFERENT)		

LANGUAGE (Enter Code) _____

1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese 9 - Korean A - Somali B - Kurdish C. - Arabic
F - French G - German J - Japanese O - Other

YES ( ) NO ( ) A. Does anyone have an emergency medical need? If **YES**, give name and explain_____

YES ( ) NO ( ) B. Is the applicant living in an Assisted Living Facility, an Adult Family Care Home, a Nursing Facility, or other institution?
If **YES**, Date Applicant Entered_____ City\County and State Applicant lived before entering _____
If outside Virginia, was placement made by a government agency? **YES ( ) NO ( )**

YES ( ) NO ( ) C. ANSWER THIS QUESTION IF APPLYING FOR MEDICAID, GENERAL RELIEF OR AUXILIARY GRANTS: Does this applicant have a spouse who does not live in the home?
If **YES**, Spouse's Name _____ Spouse's Address_____

2. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving any benefits from a social services agency, including Food Stamps, AFDC, TANF, Medicaid, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, or Refugee Cash Assistance?

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	TYPE OF BENEFITS RECEIVED
WHEN	FROM WHAT COUNTY OR CITY OR STATE	

3. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive TANF, Food Stamps, or Medicaid in two or more states at the same time? If **YES**, give date and place of conviction_____

4. **YES ( ) NO ( )** Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony?
If **YES**, explain_____

5. **YES ( ) NO ( )** Have you or anyone for whom you are applying been convicted of a felony for actions that occurred after August 22, 1996, for possession, use or distribution of drugs? If **YES**, explain_____

6. **YES ( ) NO ( )** Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, day care needs, family planning, referrals to other community organizations, or other problems or concerns. If **YES**, explain_____

INSTRUCTIONS

1. Do not write in the shaded areas. These areas are for agency use only.

2. Unfold this page. Use this folded page to complete **SECTION A: GENERAL INFORMATION.** Answer the questions in **SECTION A** for everyone who lives in your home, even if you are not applying for that person. You may leave questions about citizenship, immigration and Social Security Number blank for anyone for whom you are NOT requesting assistance.

3. Answer the questions in **SECTION B: RESOURCES,** unless you are applying for TANF or Children's Health Insurance /FAMIS, for everyone for whom you are applying. In addition, if applying for **TANF or Medicaid** also provide resource information for the following persons:

   Medicaid: Spouse and children under age 21 who live with a person for whom you are applying.
   Parents who live with a child under age 21.
   Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.

4. Answer the questions in **SECTION C: INCOME** for everyone for whom you are applying. In addition, if applying for **TANF or Medicaid or Children's Health Insurance or FAMIS** also provide income information for the following persons:

   TANF: Children age 18 or under, even if you are not applying for that child.
   Stepparent of the children for whom you are applying.

   Medicaid: Spouse and children under age 21 who live with a person for whom you are applying.
   Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.

   Children's Health Insurance/FAMIS Parents and stepparents who live with a child under age 21.

5. After completing Sections A, B, and C, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.

Food Stamps	**Section D** pp. 8-9
TANF/Medicaid	**Section E** p. 10
Refugee Cash and Medical Assistance	**Section E** p. 10 **only** for children age 18 and under
Children's Health Insurance/FAMIS	**Section F** p. 11
Medicaid/Auxiliary Grants/General Relief	**Section G** p. 11
General Relief	**Section E** p. 10 **only** for children under age 18 **Sections I & J** p. 12
State and Local Hospitalization	**Section H** p. 12
Emergency Assistance	**Section J.** p. 12
Auxiliary Grants	**Section K** p. 12

6. Read **YOUR RESPONSIBILITIES** on page 13.

7. Read and complete **VOTER REGISTRATION** on page 13 of this application.

8. Read and complete the last page of this application. Be sure to sign and date the application.

A. GENERAL INFORMATION (ALL APPLICANTS MUST COMPLETE THIS SECTION)

1. EVERYONE IN YOUR HOME **LIST EVERYONE LIVING IN YOUR HOME**, even if you are not applying for assistance for that person. **LIST YOURSELF ON LINE #1.** Check (√) **YES ( ) NO ( )** Do you expect any change in who lives in your home, either this month or next month? If YES, explain: _____ _____ _____ LAST NAME, FIRST, MI, AND MAIDEN (DO NOT make any entry in the ID# space)	2. TEMPORARILY AWAY FROM HOME Is this person temporarily away from home? Check (√) **YES** or **NO** **If YES**, give the date the person left and expected return date If more than 60 days, give the reason for the absence.	3. RELATIONSHIP TO PERSON ON LINE #1 Give the relationship of each person to the person listed on Line #1.	4. TYPE OF ASSISTANCE REQUESTED (Check (√) type of assistance requested for each person. If no assistance is requested, check **NONE** for that person.										
			FOOD STAMPS	TANF	MEDICAID/CHILDREN'S HEALTH INSURANCE/FAMIS	GENERAL RELIEF	EMERGENCY ASSISTANCE	STATE & LOCAL HOSPITALIZATION	AUXILIARY GRANTS	REFUGEE CASH ASSISTANCE	REFUGEE MEDICAL ASSISTANCE	NONE
1 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											
2 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											
3 ID#	YES ( ) NO ( ) Date Left_____ Expected =Return Date_____ Reason											
4 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											
1 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											
6 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reaon											
7 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											
8 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											

Determine reason person is away.

Determine if any parents or spouses live in the home,
Determine if person under 18 are under parental control,
Determine if anyone is a payee for anyone else

Determine living arrangement, such as subsidized housing for elderly, hospital, incarceration, etc.

If person is in ALF nursing facility, state hospital, or CBC, determine if a spouse, dependent, child, or dependent relative is in the home.

Determine living arrangement of the minor parent.

USE THE FOLDOUT TO COMPLETE THIS SECTION

5. U.S. CITIZEN Check (√) YES or NO If YES, do not answer Question 6. You may leave this blank for anyone not in the assistance request	6. ANSWER ONLY IF AN ALIEN Give the **Alien Number** and **Date of Entry** for anyone for whom you are requesting assistance. You may leave this blank for anyone not in the assistance request.	7. PLACE OF BIRTH Give the **State** if born in the U.S. or the **Country** if born outside of the U.S. 8. DATE OF BIRTH	9a. RACE (not required) Give the **code from the list at the bottom of the page** to show Race.	9b. ETHNICITY (not required) Give the **code** to show ethnicity. 1 - Hispanic or Latino 2 - Not Hispanic or Latino	10. SEX Give the **code** to show Sex. M - Male F - Female	11. SOCIAL SECURITY NUMBER Give the number for anyone for whom you are requesting assistance.	12. MARITAL STATUS Give the **code** to show Marital status. 1 - Married 2 - Never Married 3 - Divorced 4 - Widowed 5 - Separated	13. VETERAN OR DEPENDENT OF A VETERAN Check (√) YES or NO
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )

Race Code List: 1 - White 2 - Black/African-American 3 - American Indian/Alaskan Native 4 - Asian 5 - Native Hawaiian/Other Pacific Islander 6 - American India/Alaskan Native and White 7 - Asian and White 8 - Black/African-American and White 9 - American Indian/Alaskan Native and Black/African-American A - Asian and Black B - Other

For Aliens, photocopy INS document. Inquire if requesting emergency care. Determine if sponsored. Obtain sponsor's name address, income, and resources.
For Asylees, verify date asylum was granted.
For Veterans, make referral to V.A.
For Medical Expenses, determine retroactive Medicaid entitlement.

USE THE FOLDOUT TO COMPLETE THIS SECTION

14. MEDICAL EXPENSES DURING THE 3 MONTHS BEFORE THIS MONTH. Check (√) YES or NO If YES, give the Date of the Expense.	15. EDUCATION Give the Last Grade Completed in school. Check (√) YES or NO Is the person a High School (HS) or GED graduate? Check (√) YES or NO Is the person Currently Enrolled in school? If YES, give the school name and use one of the codes to show enrollment. FT - Enrolled full time HT - Enrolled half time LT - Enrolled less than half time	SCHOOL NAME	ENROLLMENT CODE	16. DISABILITY/ PREGNANT STATUS Give the code to show Disability/Pregnant Status ND - Not disabled DS - Disabled BL - Blind CD - Needed to care for disabld person PG - Pregnant	17. ANSWER ONLY IF DISABLED A. Check (√) if the disability reduces or prevents the ability to work or to obtain work. B. Check (√) if the disability reduces or prevents the ability to care for a child in the home. C. Check (√) if the disability requires someone to be in the home to provide care.	18. ANSWER ONLY IF PREGNANT AND APPLYING FOR MEDICAID Give the Conception month and year and the Expected Delivery Date, and the number of Unborn Children.
YES ( ) NO ( ) Date	A. Last Grade Completed: ________ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception Delivery # Unborn
YES ( ) NO ( ) Date	A. Last Grade Completed: ________ B. ( ) YES ( ) NO HS or GED Graduat C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception Delivery # Unborn
YES ( ) NO ( ) Date	A. Last Grade Completed: ________ B. ( ) YES ( ) NO HS or GED Graduat C. ( ) YES ( ) NO Currently Enrolled e				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception Delivery # Unborn
YES ( ) NO ( ) Date	A. Last Grade Completed: ________ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception Delivery # Unborn
YES ( ) NO ( ) Date	A. Last Grade Completed: ________ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception Delivery # Unborn
YES ( ) NO ( ) Date	A. Last Grade Completed: ________ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception Delivery # Unborn
YES ( ) NO ( ) Date	A. Last Grade Completed: ________ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception Delivery # Unborn
YES ( ) NO ( ) Date	A. Last Grade Completed: ________ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception Delivery # Unborn

B. RESOURCES

Do not complete this section if you are applying only for TANF, Children's Health Insurance, FAMIS, or Medicaid for parents of dependent children. For all other programs, answer the resource questions for everyone for whom you are applying. If applying for Medicaid for aged, blind, or disabled adults or medically needy children, also provide resource information for the additional persons indicated on the INSTRUCTIONS page. Include any resources anyone owns, is currently buying, or is heir to. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the percentage (%) of the resource owned by that person. TALK TO YOUR ELIGIBILITY WORKER IF YOU NEED HELP ANSWERING THESE QUESTIONS, INCLUDING THE PERCENTAGE OWNED.

YES ( ) NO ( ) 1. Cash on hand and not in a bank? If **YES**, list owner(s)_____ Amount_____

YES ( ) NO ( ) 2. Checking account, savings or investment account, credit union account, Christmas Club account, CDs or money market account, individual development account, patient funds for people in a nursing facility or Assisted Living Facility, or special welfare fund account? List all accounts, even if there is no money in the account. If **Yes** to savings or investment account, has the savings account been set up to pay for school expenses, to make a down payment on a house, or to start a business? Check (√) **YES ( ) NO ( )** If the savings account is to pay for school expenses, list the person(s) whose expenses will be paid _____.If the savings or investment account is for another purpose, explain _____

OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED

YES ( ) NO ( ) 3. Stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, or deeds of trust?

OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	AMOUNT $	DATE ACQUIRED

YES ( ) NO ( ) 4. Has anyone sold, transferred, or given away any resources in the last 3 months if applying for Food Stamps?
In the last 2 years, if applying for **General Relief**? Any resources or income in the last 5 years if applying for **Medicaid**?

PROPERTY TRANSFERRED		VALUE AT TRANSFER $	AMOUNT RECEIVED $	EXPLAIN REASON FOR TRANSFER
FROM WHOM	TO WHOM	DATE ACQUIRED	DATE TRANSFERRED	

Answer the questions below this point (5-12B) only if this is an application for Medicaid, General Relief, Emergency Assistance, State and Local Hospitalization, Auxiliary Grants, or Refugee Medical Assistance.

YES ( ) NO ( ) 5. Burial plots, burial arrangement or trust funds for burial?

OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE $ AMOUNT OWED $	DATE ACQUIRED
OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 6. Personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

OWNER(S)	TYPE	YES ( ) NO ( ) Is this property necessary to your business or trade, including farming?	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 7. Real property, including life estates, land, buildings, or mobile homes? If **YES**, do you live there? Check (√) **YES ( ) NO ( )**

OWNER(S)	TYPE (INCLUDE NUMBER OF ACRES)	YES ( ) NO ( ) Currently rented YES ( ) NO ( ) Income producing YES ( ) NO ( ) Currently for sale	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 8. Licensed or unlicensed vehicles, such as cars, trucks, vans, motorboats, motor homes, mobile homes, recreational vehicles, or motorcycles/mopeds?

OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES ( ) NO ( )	LICENSE #	VALUE $ AMOUNT OWED $	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED
OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES ( ) NO ( )	LICENSE #	VALUE $ AMOUNT OWED $	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED

YES ( ) NO ( ) 9. Health insurance?

POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT $	TYPE OF COVERAGE	PERSON(S) INSURED
POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT $	TYPE OF COVERAGE	PERSON(S) INSURED

YES ( ) NO ( ) 10. Medicare?

PERSON INSURED	CLAIM NUMBER	CHECK (√) ( ) PART A ( ) PART B	BEGIN DATE END DATE	PREMIUM	PAYMENT METHOD
PERSON INSURED	CLAIM NUMBER	CHECK (√) ( ) PART A ( ) PART B	BEGIN DATE END DATE	PREMIUM	PAYMENT METHOD

YES ( ) NO ( ) 11. Life insurance policies?

OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE $	CASH VALUE $	DATE ACQUIRED
OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE $	CASH VALUE $	DATE ACQUIRED

YES ( ) NO ( ) 12A. Does anyone expect to receive any money because of a legal suit involving personal injury or property damage? If **YES**, explain.
YES ( ) NO ( ) 12B. Does anyone expect a change in resources this month or next month? If **YES**, explain and give date change is expected.

EXPLAIN

C. INCOME (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the income questions for everyone for whom you are applying. If applying for **TANF** or **Medicaid**, also provide income information for the additional persons indicated on the INSTRUCTIONS page. And for **TANF** and **Medicaid/Children's Health Insurance/FAMIS** for children, also provide income information for the child's parent or stepparent living in the home; or any person living with the parent as husband or wife. If the parent is a minor under age 18 (for **TANF**) or under age 21 (for **Medicaid**), also provide income information for the parent of the minor parent.

1. Does anyone receive any of the following types of money from working? Check (√) **YES or NO** for each type. If **YES**, give the information requested.

YES ( ) NO ( ) Wages/salary
YES ( ) NO ( ) Contract income
YES ( ) NO ( ) Commissions, bonuses, tips
YES ( ) NO ( ) Vacation Pay
YES ( ) NO ( ) Earned sick pay
YES ( ) NO ( ) Babysitting/day care
YES ( ) NO ( ) Farming/fishing
YES ( ) NO ( ) Domestic work
YES ( ) NO ( ) Odd jobs
YES ( ) NO ( ) Other self employment
YES ( ) NO ( ) Any other money from working

PERSON RECEIVING MONEY FROM WORKING	EMPLOYER'S NAME, ADDRESS PHONE NUMBER	EMPLOYMENT BEGIN DATE	HOURS WORKED PER MONTH	RATE OF PAY	HOW OFTEN PAID	DAY OF THE WEEK PAID	GROSS MONTHLY PAY BEFORE DEDUCTIONS
				$ PER			$
				$ PER			$
				$ PER			$

2. Does anyone receive any other type of money? Check (√) **YES OR NO** for each type. If **YES**, give the information requested.

YES ( ) NO ( ) Social Security
YES ( ) NO ( ) SSI
YES ( ) NO ( ) VA benefits
YES ( ) NO ( ) Black Lung benefits
YES ( ) NO ( ) Railroad retirement
YES ( ) NO ( ) Other retirement
YES ( ) NO ( ) Child support, alimony
YES ( ) NO ( ) Military Allotment
YES ( ) NO ( ) Unemployment benefits
YES ( ) NO ( ) Worker compensation
YES ( ) NO ( ) Strike benefits
YES ( ) NO ( ) Interest, dividends
YES ( ) NO ( ) Cash gifts or contributions
YES ( ) NO ( ) Public Assistance
YES ( ) NO ( ) Room/board income
YES ( ) NO ( ) Rental Income
YES ( ) NO ( ) Prize winnings
YES ( ) NO ( ) Insurance settlement
YES ( ) NO ( ) Loans
YES ( ) NO ( ) Training allowances including WIA
YES ( ) NO ( ) Inheritance
YES ( ) NO ( ) All food, clothing, utilities, or rent
YES ( ) NO ( ) Any other type of money

PERSON RECEIVING MONEY	TYPE OF MONEY RECEIVED	HOW OFTEN RECEIVED	WHEN RECEIVED	GROSS MONTHLY AMOUNT BEFORE DEDUCTIONS
				$
				$
				$
				$

For Self Employment Income, determine expenses.
For Day Care Income, determine whether child lives in the home, number of snacks or meals, expenses.
For Roomer/Boarder Income, determine whether heat is provided, number of meals provided per day.
For Rental Income, determine whether properly is actively self-managed, expenses.
For Earned Income, determine whether earnings include EITC advance payments.
Inquire if SSI has been applied for.

For Food Stamps, investigate voluntary quit/work reduction.
For TANF, determine the day care option.
For Medicaid, determine income of spouse, dependent child, or dependent relative of person in nursing facility, state hospital, or CBC.

YES ( ) NO ( ) 3. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job or reduced hours worked in the last 60 days?

NAME OF PERSON	EMPLOYER'S NAME, ADDRESS PHONE	EMPLOYED FROM/TO	HRS./WK. WORKED	RATE OF PAY	HOW OFTEN PAID	DATE LAST PAY RECEIVED	REASON FOR LEAVING, REDUCING HOURS
				$ PER			

YES ( ) NO ( ) 4. Does anyone besides the people for whom you are applying pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? Or, does anyone totally supply food or clothing for you or someone else on a regular basis?

PERSON RECEIVING HELP	PERSON PROVIDING HELP	TYPE OF HELP RECEIVED	AMOUNT	DOES MONEY COME DIRECTLY TO YOU?	IS THIS A LOAN?	IS REPAYMENT EXPECTED
			$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )
			$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )

YES ( ) NO ( ) 5. Has anyone applied for or received student financial aid or work-study for a current school term at a college or university? Or, any school or training program beyond the high school level? Or, any school or training program for the physically or mentally disabled?

				SCHOOL EXPENSES					
NAME OF PERSON	TYPE OF FINANCIAL AID	AMOUNT	PERIOD COVERED	TUITION FEES	BOOKS/ SUPPLIES	TRANSPOR-TATION	DEPENDENT CARE	ROM & BOARD	OTHER (specify)
		$	FROM TO	$	$	$	$	$	$
		$	FROM TO	$	$	$	$	$	$

YES ( ) NO ( ) 6. Does anyone expect any change in the type of money received, employment, or hours worked, either this month or next month?

If **YES**, explain and give date: _____

YES ( ) NO ( ) 7. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?

PERSON PAYING FOR CARE	PERSON RECEIVING CARE	CHECK (√) IF DISABLED	PROVIDER'S NAME, ADDRESS, PHONE NUMBER	AMOUNT PAID
		( ) Disabled		$ PER
		( ) Disabled		$ PER

YES ( ) NO ( ) 8. Does anyone pay legally obligated child support to someone not in the household? If **YES,** person paying: _____

Person supported: _____ Amount paid and how often: _____

YES ( ) NO ( ) 9. **ANSWER ONLY IF SOMEONE IS APPLYING FOR MEDICAID AND IS BLIND OR DISABLED:** Does this person have a work related expense?

If **YES,** give amount and explain: _____

D. FOOD STAMPS

1. List the name of the person who is the head of your household: _____.

NOTE: Refer to the Benefit Programs Booklet for information about naming the Head of Household.

YES ( ) NO ( ) 2. Would you like to name an authorized representative who could apply for food stamps for you, access your food stamp account to buy food for you, or receive food stamp correspondence and notices for you? You may have only one representative who can access your benefits.

	NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)	CHECK (√) EACH DUTY AUTHORIZED FOR THAT PERSON
1		( ) Apply for food stamps ( ) Receive correspondence ( ) Receive food stamps
2		( ) Apply for food stamps ( ) Receive correspondence ( ) Receive food stamps

An authorized representative must have written permission to apply for food stamps. This permission may be given in the space above or in a letter. Only the head of the household, the spouse, or any adult member of the household age 18 or older may give permission for a representative.

YES ( ) NO ( ) 3. Is anyone living in your home NOT included on your Food Stamp application?

If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for Food Stamps is approved? Check (√) **YES ( ) NO ( ) IF YES**, list names:

_____

YES ( ) NO ( ) 4. Is anyone living in your home a roomer or a boarder? If **YES**, list names: _____

YES ( ) NO ( ) 5. Is anyone age 60 or older, **OR** approved to receive Medicaid because of a disability, **OR** receiving any type of disability check?

If **YES**, list all current medical expenses for these people, including Medicare premiums, other medical insurance premiums, medical and dental bills, psychotherapy, prescription drugs, eye glasses, dentures, hearing aids, transportation for medical services, nursing services, and any other medical bills. ALSO, indicate how you would like these medical expenses deducted in order to determine your food stamp benefits. TALK TO YOUR WORKER BEFORE ANSWERING METHOD OF DEDUCTION.

PERSON WITH EXPENSE	TYPE OF EXPENSE	AMOUNT	NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY	METHOD OF DEDUCTION
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment

YES ( ) NO ( ) 6. Does anyone have any shelter expense for rent or mortgage, real estate tax, property tax on a mobile home, home owner's insurance, electricity, gas, kerosene, coal, oil, wood, water or sewer, telephone, or initial installation fee for utilities or telephone? If **YES,** answer question a, b, and c. Then, give the information requested in boxes.

a. **YES ( ) NO ( )** Are any utilities included in your rent? If **Yes**, leave the boxes for those expenses blank.

b. **YES ( ) NO ( )** Are taxes or insurance included in your mortgage payment? If **Yes,** leave those boxes blank.

c. **YES ( ) NO ( )** Do you have an expense for telephone services? If **Yes**, does anyone living in your home but not included on your Food Stamp application help you pay your telephone bill? Check (√) **YES ( )** or **NO ( )**

If **YES**, explain: _____

EXPENSE	Rent or Mortgage	Taxes	Insurance	Electricity	Gas	Kerosene	Coal	Oil	Wood	Water/Sewer	Garbage	Installation
AMOUNT BILLED	$	$	$	$	$	$	$	$	$	$	$	$
HOW OFTEN												
WHO PAYS BILL												

YES ( ) NO ( ) 7. Does anyone have or expect to have an expense for heating or cooling the home? Or, has anyone received assistance from the Fuel Assistance Program during this past year?

If **YES**, check (√) whether you would like your food stamp benefits determined using your actual utility expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. **Actual Utility Expenses ( ) Utility Standard ( )**

If the **Utility Standard** is selected, does anyone living in your home but not included on your Food Stamp application help you pay your heating or cooling bill? Check (√) **YES ( ) NO ( )** If **YES,** explain: _____

YES ( ) NO ( ) 8. Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If temporarily staying in someone else's home, give the date you moved in: _____

If **YES,** check (√) whether you would like your food stamp benefits determined using your actual shelter expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. **Actual Shelter Expenses ( ) Homeless Shelter Allowance ( )**

YES ( ) NO ( ) 9. Does anyone have a shelter expense for a home (rented or owned) that is temporarily not lived in because of employment or training away from home, illness, or a disaster?

REASON FOR NOT LIVING THERE	DOES PERSON INTEND TO RETURN?	TYPE AND AMOUNT OF SHELTER EXPENSES	IS SOMEONE ELSE LIVING THERE?	IF SOMEONE ELSE LIVES THERE, DOES THAT PERSON PAY RENT?
	YES ( ) NO ( )		YES ( ) NO ( )	YES ( ) NO ( )

(ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)

E. FINANCIAL AND MEDICAL ASSISTANCE FOR FAMILIES WITH CHILDREN

ANSWER QUESTIONS 4, 5 AND 6 <u>ONLY</u> IF ANSWER TO QUESTION 3 IS **"SEPARATED, LIVING APART"** AND YOU ARE APPLYING FOR MEDICAID.

1. CHILD/PARENT INFORMATION List each child for whom you are applying. Then, list the names of both parents. YOU MUST IDENTIFY BOTH PARENTS IN ORDER TO RECEIVE TANF. IF YOU INTENTIONALLY MISIDENTIFY A PARENT, YOU SHALL BE PROSECUTED	**2. PARENT'S STATUS** Check if either PARENT is:				**3. REASONS FOR ABSENCE** **(Answer <u>only if</u> the answer to question 2 is "absent" and you are applying for Medicaid.)** **For each ABSENT PARENT, check reason for absence.**										**4. FINANCIAL SUPPORT** Does the ABSENT PARENT regularly provide monthly financial support? Check (√) **YES** or **NO** If **YES**, give amount, and how often received.	**5. PHYSICAL CARE** Does the ABSENT Parent regularly make sure the child eats, sleeps, bathes, dresses properly, and gets proper medical care? Check (√) **YES** or **NO**	**6. GUIDANCE** Does the ABSENT PARENT regularly particpate in the child's activities, attend school conferences, and share in decisions about discipline? Check (√) **YES** or **NO**	**7. IMMUNIZATION** (Answer **<u>only if</u> applying forTANF and the child is not in school.)** Has the child received **ALL** of the immunizations required according to the child's age? Check (√) **YES** or **NO** or **UNKNOWN**
	UNEMPLOYED	DISABLED	DEAD	ABSENT	PATERNITY NOT ESTABLISHED	DIVORCED OR MARRIAGE ANNULLED	INCAPACITATED	DESERTED	SEPARATED LIVING APART	SENTENCED BY COURT TO DO UNPAID WORK	DEPORTED	ARTIFICIAL INSEMINATION	SINGLE PARENT ADOPTION				
CHILD'S NAME																		YES ( ) NO ( ) UNKNOWN ( )
MOTHER															YES ( ) NO ( ) $ PER	YES ( ) NO (	YES ( ) NO ( )	
FATHER															YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
CHILD'S NAME																		YES ( ) NO ( ) UNKNOWN ( )
MOTHER															YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
FATHER															YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
CHILD'S NAME																		YES ( ) NO ( ) UNKNOWN ( )
MOTHER															YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
FATHER															YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
CHILD'S NAME																		YES ( ) NO ( ) UNKNOWN ( )
MOTHER															YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
FATHER															YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	

F. CHILDREN'S HEALTH INSURANCE/FAMIS

YES ( ) NO ( ) 1. Did any of the children listed above have health insurance in the past 4 months? If yes, (a) list name of child, type of insurance, such as doctor, hospital, drugs, dental, vision, etc., and the date the insurance ended; and (b) select the reason the insurance ended.

Child: _____ Type of insurance: _____

Date ended _____

Reason insurance ended:

( ) The parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage.
( ) The parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage.
( ) Child uninsurable—insurance company discontinued coverage. (Provide proof that coverage stopped by insurance company)
( ) Cost exceeded 10% of monthly income (before taxes). (Provide proof of cost of monthly premium)
( ) Stopped/dropped by someone other than parent or stepparent.
( ) Stopped/dropped Cobra policy
( ) Other _____

YES ( ) NO ( ) 2. Is any member of the family, including a stepparent who lives in the home, employed by a State or Local Government agency? If yes, list name of family member(s) and agency name: _____

YES ( ) NO ( ) 3. Does the employer of any member of the family offer health insurance for family members? If yes, list the names of the children listed on this application who can get insurance through the employer? _____

G. AGED, BLIND OR DISABLED INDIVDUALS

YES ( ) NO ( ) 1. Have you ever applied for Supplemental Security Income (SSI) or social security as a disabled person? If **YES,** date applied: _____
Check one: ( ) No Decision Yet ( ) Application Approved ( ) Application Denied

YES ( ) NO ( ) 2. If your application was denied, did you file an appeal of the denial? If yes, explain the action taken by the Social Security Administration (SSA) on the appeal request? _____

YES ( ) NO ( ) 3. Has it been less than 12 months since your most recent application for social security or SSI disability benefits was denied? If yes, list the medical conditions that you asked SSA to evaluate. _____.

YES ( ) NO ( ) 4. Has your condition changed or worsened since your most recent application for social security or SSI disability benefits was denied. If yes, explain how your condition has changed or worsened. _____

YES ( ) NO ( ) 5. Do you have a new condition that has occurred since your most recent application for social security or SSI disability benefits was denied? If yes, explain the new condition. _____

YES ( ) NO ( ) 6. Did you receive an Auxiliary Grants check that has stopped? If yes, explain when and why the payments stopped. _____
_____

YES ( ) NO ( ) 7. Did you receive a SSI check that has stopped? If yes, explain when and why the payments stopped. _____
_____

H. STATE AND LOCAL HOSPITALIZATION

YES ( ) NO ( ) Have you received or will you be receiving in-patient/out-patient hospitalization services, or ambulatory surgical services, or services through a health department clinic? If **YES**, please fill out the following:

PERSON RECEIVING SERVICES	NAME OF HOSPITAL OR CLINIC	IF SERVICE HAS ALREADY BEEN RECEIVED, GIVE THE DATES BELOW DATE ADMITTED: DATE DISCHARGED:

If you were hospitalized as the result of an accident, complete the following:

WHAT HAPPENED, WHERE, HOW	NAME, ADDRESS OR PERSON AT FAULT	IS A LIABILITY SUIT PLANNED OR IN PROGRESS? YES ( ) NO ( )

NAME, ADDRESS OF ALL INSURANCE COMPANIES INVOLVED	NAME, ADDRESS, PHONE NUMBER OF YOUR ATTORNEY

I. GENERAL RELIEF

YES ( ) NO ( ) Does anyone have any responsibility for rent or utility bills (not telephone), even if someone else helps pays?

J. GENERAL RELIEF/EMERGENCY ASSISTANCE

YES ( ) NO ( ) Does anyone have any emergency food, rent, utility (not deposits), medical, clothing, transient or relocation expenses?

DESCRIPTION AND CAUSE OF EMERGENCY

K. AUXILIARY GRANTS

YES ( ) NO ( ) 1. Do you own any household goods or personal effects which are worth more than $500, such as silver, fine china, furs, artworks, expensive jewelry, or other expensive items?

DESCRIPTION AND VALUE OF ITEMS

YES ( ) NO ( ) 2. Do you owe or did you pay in the month or application any bills you had before you entered the assisted living facility or adult family care?

DESCRIPTION OF BILLS	DATES OF BILLS	DATES BILLS PAID

YOUR RESPONSIBILITIES (READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

CHANGES

You must report the following changes for the Medicaid Program within 10 days. You must report these changes for the Auxiliary Grants and General Relief Programs the day the change occurs or the first day that the agency is open after the change occurs. The following examples of changes may include some that do not have to be reported for every program. If you are not sure whether to report a particular change, please discuss the change with your worker.

1) Change of address and any changes in shelter costs due to the move
2) Change in the persons in the household – person left, person born, etc.
3) Change in source of income, getting a new job, stopping a job, other benefits, etc.
4) Change in work hours from part-time to full-time or full-time to part-time
5) Change in rate of pay per hour/day, etc.
6) Change in the amount of monthly income received other than from a job.
7) Change in resources
8) Change in motor vehicles owned
9) Change in marital status
10) Person in home is no longer disabled
11) Change in dependent care expenses
12) Other changes that may affect eligibility for a program or the amount of assistance

You must report the following changes for the Food Stamp and Temporary Assistance for Needy Families (TANF) Programs within 10 days, but no later than the 10th day of the month after the change occurs.

1) Change in household income that exceeds 130% of the Federal poverty level. See the Change Report for amounts.
2) Change in address.
3) An eligible child has left the home.
4) Changes needed for VIEW (TANF work program).
5) Change in work hours for some food stamp recipients.

PENALTIES FOR FOOD STAMP VIOLATIONS

You must not give false information or hide information to get food stamps. You must not trade or sell EBT cards. You must not use food stamp benefits to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's, EBT card for your household.

Anyone who intentionally breaks any of these rules could be barred from the Food Stamp Program for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); subject to $250,000 fine, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

Anyone who intentionally gives false information or hides information about identity or residence to get food stamps in more than one locality at the same time could be barred for 10 years.

Anyone court convicted of trading or selling food stamps of $500.00 or more could be barred permanently.

Anyone court convicted of trading food stamps for a controlled substance could be barred for 24 months for the 1st violation, permanently for the 2nd violation.

Anyone court convicted of trading food stamps for firearms, ammunition, or explosives could be barred permanently for the first violation.

Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.

PENALTIES FOR TANF VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF or to receive supportive or transitional services such as child care or assistance with transportation.

If you are found guilty of intentionally breaking these rules, you will be ineligible to receive TANF for yourself for 6 months (1st violation), 12 months (2nd violation), or permanently (3rd violation). In addition, you may be prosecuted under Federal or State law.

Anyone convicted of misrepresenting his or her residence to get TANF, Medicaid, Food Stamps or SSI in two or more states is ineligible for TANF for 10 years.

Anyone convicted of a drug-related felonyfor actions that occurred after August 22, 1996, could be barred permanently.

INFORMATION ABOUT THE DIVISION OF CHILD SUPPORT ENFORCEMENT (DCSE)

In order to receive TANF, you are required to assign all of your rights to financial support paid to you and to everyone else for whom you are receiving TANF. You must give to DCSE any support payments you receive after you receive your first TANF check. By accepting the TANF check, you are agreeing to assign these rights.

VOTER REGISTRATION

Check one of the following:

( ) I am not registered to vote where I currently live now, and would you like to register to vote here today. I certify that a voter registration application form was given to me to complete. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to complete your voter registration application form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote today.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, you right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 786-6551.

Agency Use Only: Face-to-face interview not required. A voter registration form was mailed.

BY MY SIGNATURE BELOW, I DECLARE:

- I understand all othe information in the GENERAL INFORMATION and the YOUR RESPONSIBILITIES sections of this application.
- I understand that if I refuse to cooperate with any review of my eligibility including review by Quality Control, my benefits may be denied until I cooperate.
- I understand that if my application is for Food Stamps, failure to report or verify any of my expenses will be seen as a statement by my household that I do not want to receive a deduction for unreported expenses.
- I understand that Medicaid, FAMIS, and DMAS contractors may exchange information relating to my child(ren)'s coverage with local educational agencies, to assist with application, enrollment, administration, and billing for services provided to my child in schools. I understand that I can revoke the consent to disclose information at any time.
- I understand that to receive benefits from the Medicaid/Children's Health Insurance/FAMIS programs, I must agree to assign my rights and the rights of anyone for whom I am applying to medical support and other third-party payments to the Department of Medical Assistance Services. If I do not agree to assign my rights, I will be ineligible for Medicaid.
- I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219.
- I understand that I have the right to file a complaint if I feel I have been discriminated against because of race, color, national origin, sex, age, disability, or religious or political beliefs.
- I understand that if I am applying for Medicaid/Children's Health Insurance/FAMIS for my children, I can apply for and receive services from the Division of Child Support Enforcement, but failure to apply for the services will not affect my child(ren)'s eligibility. If I am applying for Medicaid, failure to cooperate my cause my ineligibility for Medicaid.
- I understand that I have the right to appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application within specified time frames10 days; (2) denied benefits from the programs for which I applied; or (3) dissatisfied with any other decision that affects my receipt of Medicaid/Children's Health Insurance. For FAMIS, there will be no opportunity for review of a negative action if the sole basis for the action is exhaustion of funding.
- I will report any changes in my situation within the time frames specified on page 13 to my local department of social services.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that if I help someone complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted
- I understand that my signature on this application certifies, under penalty of perjury, that I am (unless applying for emergency services only) a U.S. Citizen or alien in lawful immigration status.
- I authorize the Department of Social Services and the Department of Medical Assistance Services to obtain any verification necessary to both determine and review financial or medical assistance eligibility. This authorization includes the release of any medical or psychological information obtained from any source to any state or local agency that may review this application and the release to the Department of Medical Assistance Services of any information in any medical records pertaining to any services received by me or anyone for whom I applied. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I received the Benefit Programs Booklet **YES ( ) NO ( )** **MEDICAID APPLICANTS**: I received the Medicaid Handbook **YES ( ) NO ( )**

TANF APPLICANTS: The diversionary assistance program was explained to me. **YES ( ) NO ( )**
The family cap provision was explained to me. **YES ( ) NO ( )**

I filled in this application myself. **YES ( ) NO ( )** If **NO**, it was read back to me when completed. **YES ( ) NO ( )**

APPLICANT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	SPOUSE'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK (NOT NEEDED FOR FOOD STAMPS)	DATE
WITNESS TO MARK OR INTERPRETER	DATE	WORKER'S SIGNATURE	DATE

Complete the box below if this application was completed for the applicant by someone else.

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME) (WORK)		REALATIONSHIP TO APPLICANT

APPLICATION FOR BENEFITS

FORM NUMBER - 032-03-824

PURPOSE OF FORM - To record a household's request for assistance and to provide information about the current situation needed to determine eligibility.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The application is to be completed by or on behalf of the applying household. The completed application may be mailed to the agency or completed at the agency prior to or during an interview. The completed application is to be filed in the eligibility case record. The application must be retained for a minimum of three years.

The application may be used to apply for benefits of other programs if assistance is requested within three months of the original filing date. The date of the application in this instance is the date of the secondary request.

INSTRUCTIONS FOR PREPARATION OF FORM - General instructions appear of the form for completion.

If changes need to be made after the application is completed, the applicant should write the revised information near the original entry. The applicant must initial and date the changes. Except for agency-use sections, eligibility workers may not add to or write on a completed application.

Commonwealth of Virginia
Department of Social Services
ELIGIBILITY REVIEW – PART A

CASE NAME	CASE NUMBER	PROGRAM(S)	LOCALITY	WORKER	DATE RECEIVED
CASE NAME	CASE NUMBER	PROGRAM(S)	LOCALITY	WORKER	DATE RECEIVED

This is a review to determine if you continue to be eligible for benefits. Please give correct and complete information on both Part A (this form) and Part B (Separate Form).
IF YOU ARE REPORTING A NEW HOUSEHOLD MEMBER, COMPLETE THE INFORMATION ON THE BACK OF THIS PAGE FOR THE NEW MEMBER.

A. HOUSEHOLD INFORMATION

1. Give your name, address and phone number.

NAME	PHONE NUMBER (HOME) (WORK)
ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)	DIRECTIONS TO HOME
MAILING ADDRESS (IF DIFFERENT)	

2. List yourself on the first line. Then, list everyone else living in your home, **even if you are not applying for that person**. Include people temporarily away and check the "AWAY" block for them. Give the information requested for each person.

NAME (IF AWAY, CHECK AWAY BLOCK)		PROGRAM(S) REQUESTED						You may leave this blank for anyone not in the assistance request.			CHECK (√) IF IN SCHOOL?		
LAST, FIRST, MIDDLE INITIAL (MAIDEN)	AWAY	FOOD STAMPS	TANF	MEDICAID	IF OTHER, SPECIFY	NONE	RELATION-SHIP TO YOU	SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS	YES	NO	IF IN SCHOOL NAME OF SCHOOL

If you answer "YES" to any of the following questions, please explain below.

YES ( ) NO ( ) 3. Is anyone in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony?
YES ( ) NO ( ) 4. Has anyone been convicted of a felony that occurred after August 22, 1996, for possession, use, or distribution of drugs?
YES ( ) NO ( ) 5. Is anyone now blind, totally incapacitated, too ill or injured to work, pregnant, or needed to care for an incapacitated person?
YES ( ) NO ( ) 6. Have any of your children received any immunizations since approval of your original application or since your most recent review?
YES ( ) NO ( ) 7. Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your address or identity to receive TANF (AFDC), Food Stamps, or Medicaid in two or more areas at the same time?

If YES, explain: _____

_____

8. **NEW HOUSEHOLD MEMBER INFORMATION** – Give the following information for any new household member you are reporting for the first time. For **TANF and FOOD STAMPS**, also give this information for any new member you have verbally reported since your original application or since your most recent eligibility review.

NAME LAST NAME, FIRST, MI (MAIDEN)	PROGRAM(S) REQUESTED	RELATION-SHIP TO YOU	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	** RACE	** HISPANIC YES	HISPANIC NO	SEX	MARITAL STATUS	CITIZEN-SHIP*	ALIEN REGISTRATION NUMBER*	LAST GRADE	CHECK (√) IF IN SCHOOL YES	SCHOOL NO	CHECK (√) IF A VETERAN YES	VETERAN NO

* **-You may leave this blank for anyone not in the assistance request.**
** **- Not required.**

YES ( ) NO ( ) 9. Is anyone listed above blind, totally incapacitated, too ill or injured to work, pregnant, or needed to care for an incapacitated person? If YES, explain: _____

YES ( ) NO ( ) 10. Is anyone listed above in violation of parole or probation, or fleeing capture to avoid prosecution or punishment of a felony? If Yes, explain: _____

YES ( ) NO ( ) 11. Has anyone listed above been convicted of a felony that occurred after August 22, 1996, for possession, use, or distribution of drugs? If YES, explain: _____

YES ( ) NO ( ) 12. Has anyone listed above ever been convicted of making false or misleading statements about your address or identity to receive TANF (AFDC), Food Stamps, or Medicaid in two or more areas at the same time? If YES, give date and place of conviction: _____

YES ( ) NO ( ) 13. **(DOES NOT APPLY TO FOOD STAMPS OR TANF)**: Does anyone listed above have any unpaid medical expenses during the last 3 months?

YES ( ) NO ( ) 14. **(DOES NOT APPLY TO FOOD STAMPS)**: If applying for children, list the name(s) and address(es) of any absent parent(s): _____

YES ( ) NO ( ) 15. **(DOES NOT APPLY TO FOOD STAMPS OR TANF)**: If the parents are separated and living apart, does the absent parent(s) provide financial support, physical care, or guidance? If YES, explain: _____

ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT: As long as you are covered by Medicaid or State/Local Hospitalization (SLH), you are required to assign all of your rights to medical support to the Department of Medical Assistance Services (DMAS) and give to DMAS any payment for medical services you receive from another insurer. You are also required to assign these same rights for everyone else for whom you have the legal right to do so. Failure to assign your rights will make you ineligible for Medicaid or SLH. Failure to assign the rights of anyone else will not make that person ineligible for Medicaid. If you are unwilling to assign the rights of a new household member(s), initial the block below and list the name(s) of the person(s) whose rights you do not wish to assign. Otherwise, your signature indicates you agree to assign the rights of the new household member(s).

☐ I refuse to assign the rights of _____

_____ _____ _____ _____
Your Signature or Authorized Representative's Signature or Mark Date Witness for Mark Date

By my signature below, I declare that the household member(s) for whom I am requesting Food Stamps, TANF, Medicaid (unless I am applying for emergency medical services only), is/are either a U.S. citizen(s) or alien(s) in lawful immigration status, and I declare under penalty of law that all information on this form is correct and complete to the best of my knowledge and belief. The Virginia Department of Social Service is an equal opportunity provider. I understand that if there is a food stamp claim against my household, the information on this application, including all SSNs, may be referred to federal and state agencies as well as private claims collection agencies for claims collection action.

_____ _____ _____ _____
Your Signature or Authorized Representative's Signature or Mark Date Witness for Mark Date

Commonwealth of Virginia
Department of Social Services
ELIGIBILITY REVIEW - PART B

CASE NAME	CASE NUMBER	PROGRAM(S)	LOCALITY	WORKER'S	DATE RECEIVED
CASE NAME	CASE NUMBER	PROGRAM(S)	LOCALITY	WORKER'S	DATE RECEIVED

B. RESOURCES Answer for everyone for whom you are applying. Include any resources anyone owns, is buying, or is heir to. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the percentage (%) of the resources owned by that person. **Talk to your eligibility worker if you need help answering these questions, including help with the percentage owned.**

☐ YES ☐ NO 1. Does anyone have cash, money in checking/savings/credit union/Christmas Club/money market/individual development account/or any other account, CD's, patient funds, special welfare accounts, stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, deeds of trust, or burial plots/arrangements/trust funds? Has a savings or other investment account been set up to pay for school, to make a down payment on a house, to start a business, or for another purpose? Check(✓) ☐ YES ☐ NO

If the savings or other investment account is for **school expenses**, give name of person whose expenses will be paid: _____

If the savings or investment account is for another purpose, explain _____

OWNER(S)	TYPE (ACCOUNT#)	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT OR VALUE $	DATE ACQUIRED
OWNER(S)	TYPE (ACCOUNT#)	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT OR VALUE $	DATE ACQUIRED
OWNER(S)	TYPE (ACCOUNT#)	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT OR VALUE $	DATE ACQUIRED

☐ YES ☐ NO 2. Does anyone own any personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

OWNER(S)	TYPE	YES ( ) NO ( ) Is this property used in your business or trade, including farming?	VALUE $ AMOUNT OWED $	DATE ACQUIRED

☐ YES ☐ NO 3. Does anyone own any real property, including life estates, inherited property, land, buildings, or mobile homes? If YES, do you live there? Check (✓) ☐ YES ☐ NO

OWNER(S)	TYPE	YES ( ) NO ( ) Currently rented YES ( ) NO ( ) Income-producing YES ( ) NO ( ) Currently for sale	VALUE $ AMOUNT OWED $	DATE ACQUIRED

☐ YES ☐ NO 4. Does anyone own vehicles, such as cars, trucks, vans, motorboats, motor homes, mobile homes, recreational vehicles, or motorcycles/mopeds?

OWNER(S)	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID #	CURRENTLY LICENSED ☐YES ☐NO	LICENSE #	VALUE $ AMOUNT OWED $	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED
OWNER(S)	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID #	CURRENTLY LICENSED ☐YES ☐NO	LICENSE #	VALUE $ AMOUNT OWED $	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED

☐ YES ☐ NO 5. Does anyone have health insurance?

POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT $	TYPE OF COVERAGE	PERSON(S)INSURED

❑ YES ❑ NO 6. Does anyone have Medicare?

PERSON INSURED	CLAIM NUMBER	CHECK (✓) ☐ PART A ☐ PART B	BEGIN DATE END DATE	PREMIUM $	PAYMENT METHOD
PERSON INSURED	CLAIM NUMBER	CHECK (✓) ☐ PART A ☐ PART B	BEGIN DATE END DATE	PREMIUM $	PAYMENT METHOD

❑ YES ❑ NO 7. Does anyone have life insurance, retirement insurance, or other related types of insurance policies? **(Not required for Food Stamps)**

OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE	CASH VALUE	DATE ACQUIRED
					$	$	

❑ YES ❑ NO 8. Has anyone sold, transferred or given away any resources in the last 3 months (for **Food Stamps**), in the last 2 years (for **TANF** or **General Relief**), or resources **or income** in the last five years (for **Medicaid**)? If Yes, explain: _____

C. INCOME

Answer for everyone for whom you are applying. For **TANF** and **Medicaid** for children, also provide income information for the child's parent or stepparent living in the home; or any person living with the parent as husband or wife. If the parent is a minor under age 18 (for **TANF**) or under age 21 (for **Medicaid**), also provide information for the parent of the minor parent.

❑ YES ❑ NO 1. Does anyone receive any money from any source? Include money received from self-employment, pensions, income-producing property, support or contributions. If **YES**, give the information requested. If the money is received from working, give employment information.

PERSON RECEIVING MONEY	TYPE OF OF MONEY	HOW OFTEN RECEIVED	WHEN RECEIVED	GROSS MONTHLY AMT. BEFORE DEDUCTIONS	EMPLOYER'S NAME, ADDRESS, PHONE NUMBER	EMPLOYMENT BEGIN DATE	HRS/MONTH WORKED
				$			
				$			
				$			
				$			

❑ YES ❑ NO 2. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job, or reduced hours worked since you applied? If **YES**, give name and explain: _____

❑ YES ❑ NO 3. Does anyone besides the people on your case pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? OR, does anyone totally supply food, shelter or clothing for you or someone else on a regular basis? If **YES**, give name, amount, and explain: _____

❑ YES ❑ NO 4. Has anyone applied for or received student financial aid or work-study for a current school term at any college, university, school or training program beyond the high school level, or any school or training program for persons with a physical or mental disability?

NAME OF PERSON	TYPE OF FINANCIAL AID	AMOUNT	PERIOD COVERED	TUITION/ FEES	BOOKS SUPPLIES	TRANSPOR-TATION	DEPENDENT CARE	ROOM & BOARD	OTHER (Specify)
		$	FROM TO	$	$	$	$	$	$

❑ YES ❑ NO 5. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability? If **YES**, give name, amount and explain: _____

❑ YES ❑ NO 6. Does anyone pay legally obligated child support to someone not in the household? If **YES**, give name of person paying, person supported, and amount: _____

D. FOOD STAMPS

1. List the name of the person who is the head of your household.
NOTE: Refer to the *Benefit Programs Booklet* for additional information.

HEAD OF HOUSEHOLD

❑ YES ❑ NO 2. Would you like to name an authorized representative who could apply for food stamps for you, receive or use your food stamp benefits in grocery stores for you, or receive food stamp correspondence and notices for you?

NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)	CHECK(✓) EACH DUTY AUTHORIZED FOR THAT PERSON
	❑ APPLY FOR FOOD STAMPS ❑ RECEIVE CORRESPONDENCE ❑ RECEIVE OR USE FOOD STAMP BENEFITS

❑ YES ❑ NO 3. Is anyone living in your home NOT included in your Food Stamp application? If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for Food Stamps is approved?
Check (✓) ❑ YES ❑ NO

❑ YES ❑ NO 4. Is anyone living in your home a roomer or boarder? If **YES**, list names: _____

❑ YES ❑ NO 5. Is anyone age 60 or older OR approved to receive Medicaid because of a disability OR receiving any type of disability check? If **YES**, list all current medical expenses for these people. TALK TO YOUR WORKER BEFORE ANSWERING METHOD OF DEDUCTION.

PERSON WITH EXPENSE	TYPE OF EXPENSE	AMOUNT	NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY	METHOD OF DEDUCTION
		$		❑ LUMP SUM ❑ MONTHLY AVERAGE ❑ EXPECTED PAYMENT
		$		❑ LUMP SUM ❑ MONTHLY AVERAGE ❑ EXPECTED PAYMENT

❑ YES ❑ NO 6. Does anyone have any of the following shelter expenses? Check (✓) here ❑ if these expenses are for a house not lived in.

EXPENSES	RENT OR MORTGAGE	TAXES	INSURANCE	ELECTRICITY	GAS	KEROSENE	COAL	OIL	WOOD	WATER/SEWER	GARBAGE	TELEPHONE	INSTALLATION
AMOUNT BILLED	$	$	$	$	$	$	$	$	$	$	$	$	$
HOW OFTEN													
WHO PAYS BILL													

a. Households which have a heating or cooling expense OR received fuel assistance during this past year can use actual utility expenses or a standard amount for these expenses called the "Utility Standard." Check (✓) which amount you would like to use. ❑ Actual utility expenses ❑ Utility standard If Utility Standard, does anyone living in your home but not in your case help you pay heating/cooling? Check (✓) ❑ YES ❑ NO If **YES**, explain _____

b. Households which do not have a permanent residence can use actual shelter expenses or a standard amount for these expenses called the "Shelter Standard." Check (✓) which amount you would like to use. ❑ Actual shelter expenses ❑ Shelter standard If temporarily staying in someone else's home, give date moved in _____.

E. FINANCIAL AND MEDICAL ASSISTANCE FOR CHILDREN

❑ YES ❑ NO 1. Has the absent parent(s) changed the amount of financial support, physical care, or guidance regularly provided to the children? If **YES,** explain: _____

❑ YES ❑ NO 2. Has the legal parent become disabled such that he or she is unable to work? If **YES,** explain: _____

❑ YES ❑ NO 3. Do you have any new information that would help us locate the absent parent(s)? If **YES,** explain: _____

F. AUXILIARY GRANTS

❑ YES ❑ NO 1. Do you own any household goods or personal effects which are worth more than $500? If **YES,** and you did not report these items in the Resource Section, list the items and their value here: _____

G. CHANGES EXPECTED THIS MONTH OR NEXT: _____

H. VOTER REGISTRATION (FOOD STAMPS, TANF, MEDICAID ONLY)

ANSWER ONLY IF YOU ARE APPLYING FOR FOOD STAMPS, TANF, OR MEDICAID. IF YOU DO NOT RESPOND, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT REGISTER TO VOTE AT THIS TIME.

Check (✓) one of the following:

YES ( ) NO ( ) If you are not registered to vote where you currently live now, would you like to register to vote here today? By checking this question "yes," I certify that a voter registration application form was given to me to complete. (if you would like help in filling out the vote registration application form, we will help you. The decision to accept help is yours. You also have the right to complete your voter registration application form in private.)

YES ( ) NO ( ) I am already registered to vote at my current address. (If already registered at your current address, you are eligible to register to vote.)

YES ( ) NO ( ) I do not want to apply to register to vote today.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be use for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 786-6551.

Agency Use Only: ❑ Face-to-face interview not required. A voter registration form was mailed.

BY MY SIGNATURE BELOW, I DECLARE UNDER PENALTY OF PERJURY THAT ALL OF THE FOLLOWING IS TRUE:

I received the Benefit Programs Booklet when I first applied or at this review. I understand:

- All of my responsibilities listed in the Benefit Programs Booklet, including my responsibility to report required changes on time.
- If I give false, incorrect, or incomplete information, or do not report required changes on time, I may be breaking the law and could be prosecuted.
- If I helped someone complete this form so as to get benefits he or she is not entitled to, I may be breaking the law and could be prosecuted.
- If I refuse to cooperate with any review of my eligibility, including reviews by Quality Control, my benefits may be denied until I cooperate.
- If my application is for Food Stamps, failure to report or verify of my expenses will be seen as a statement by my household that I do not want to receive a deduction for unreported expenses.

All information on this form is correct and complete to the best of my knowledge and belief.

My signature authorizes the release to this agency of all information necessary to both determine and review my eligibility AND the release of any medical or psychological information obtained from any source to the state or local agency that may review this application for financial or medical assistance. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I filled in this application myself: ❑ YES ❑ NO If **NO,** it was read back to me when complete: ❑ YES ❑ NO

YOUR SIGNATURE OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	SPOUSE'S SIGNATURE OR MARK (NOT NEEDED FOR FOOD STAMPS)	DATE
WITNESS TO MARK OR INTERPRETER	**DATE**	**WORKER'S SIGNATURE**	**DATE**

Complete the box below if this application was completed for the applicant by someone else.

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME) **(WORK)**		**RELATIONSHIP TO APPLICANT**

ELIGIBILITY REVIEW FORMS

FORM NUMBER - 032-03-729A
032-03-729B

PURPOSE OF FORM - (1) To record a household's situation in order to review eligibility; and (2) to gather information about a new household member who is to be added at the time of the review. Though not required for food stamps, the review forms may be used to gather information about a new household member who is to be added during the certification period.

USE OF FORM - These forms are limited to reviews. They may not be used in lieu of an application to either apply for benefits or to protect the date of application.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - These forms are completed at the time of the eligibility review or when new household members are added. Completed forms are to be filed in the eligibility case record.

INSTRUCTIONS FOR PREPARATION OF FORMS - For reviewing eligibility, the front of Part A and all of Part B must be completed. If new household members are to be added at the time of the review, the back of Part A must also be completed.

Requirements for adding new household members between reviews vary by program. For food stamps, a new member may be added based on information provided verbally by a responsible household member. The household does not have to annotate the application, sign and date the application again, or complete the back of Part A. At a minimum, the household must provide a verbal statement of the information on the back of Part A about the new member and note income, resource, or expense changes. The back of Part A and Part B, in its entirety, must be completed in writing at the end of the next review.

Commonwealth of Virginia
Department of Social Services

EVALUATION OF ELIGIBILITY

1. GENERAL INFORMATION

CASE NAME	CASE NUMBER	PROGRAM	APPLICATION DATE	INTERVIEW DATE
SECONDARY CASE NAME	SECONDARY CASE NUMBER			
IDENTITY (NAME)	VERIFICATION			

HEAD OF HOUSEHOLD ADULT PARENT/PARENTAL CONTROL? ☐ Y ☐ N DESIGNATED BY HH ☐ AGENCY ☐	FACE-TO-FACE INTERVIEW? ☐ Y ☐ N IF NO, REASON:

ADDRESS	SECONDARY ADDRESS, TYPE		INSTITUTIONAL STATUS Date Entered NF ☐ CBC ☐ ACR ☐
VERIFICATION/REMARKS	VIRGINIA RESIDENT? ☐ Y ☐ N	ACR/AFC RATE:	DMAS-96 ☐ Y ☐ N SAR ☐ Y ☐ N

2. MEMBER INFORMATION

	HH/UNIT MEMBERSHIP CHECK (√) IF INCLUDED						PERMANENT VERIFICATIONS CHECK (√) IF REQ. MET				FSET/ESP/VIEW REGISTRATION OR REFERRAL	ATTENDING SCHOOL?	DEPRIVATION (MED - ONLY EFF 7/1/99)	IMMUNIZATION REQUIREMENT MET?
NAME OR MBR#	FS	TANF	MED	AG	MEDICAID/AG CATEGORY	OTHER (LIST)	SSN	DOB	CIT	REL	IF YES, DATE IF NO, REASON	DOCUMENT TRUANCY	GIVE REASON	GIVE VERIFICATION
											☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
											☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
											☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
											☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
											☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
											☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
											☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

NAME	PROGRAM	REASON FOR EXCLUSION, DISQUALIFICATION OR INELIGIBILITY	TIME PERIOD

ASSIGNMENT OF RIGHTS? ☐ Y ☐ N	NOTICE OF COOPERATION AND GOOD CAUSE SIGNED? ☐ Y ☐ N GOOD CAUSE CLAIMED? ☐ Y ☐ N IDENTITY EXCEPTION CLAIMED? ☐ Y ☐ N	LIVING WITH SPECIFIED RELATIVE/GUARDIAN ☐ Y ☐ N

DEPRIVATION, TRUANCY, PREGNANCY, CONCEPTION/DELIVERY DATE, FOSTER CARE/ADOPTION STATUS, DISABILITY/BLINDNESS OR OTHER DOCUMENTATION

3. MEDICAID

RETROACTIVE DETERMINATION NECESSARY ? ☐ Y ☐ N RETROACTIVE PERIOD _____	POTENTIALLY PROTECTED MEMBERS PROTECTED MEMBERS (INCLUDED STATUS)	COMMUNITY SPOUSE? ☐ Y ☐ N

4. DOCUMENTATION OF UNIT OR HH MEMBERSHIP, MEDICAID PROTECTED STATUS, VOLUNTARY QUIT, WORK REDUCTION, WORK REQUIREMENT.

5. RESOURCES (EVALUATE SAVINGS OR INVESTMENT ACCOUNT FOR ANY PURPOSE LEADING TO SELF-SUFFICIENCY)

CASH ☐ Y ☐ N ACCOUNTS ☐ Y ☐ N STOCKS/BONDS TRUST FUNDS ☐ Y ☐ N PENSION PLANS RETIREMENT ☐ Y ☐ N

MBR	TYPE	AMOUNT	INSTITUTION, ACCT NAME, ACCT #	VERIFICATION, CALCULATIONS, WITHDRAWLS	PROGRAM(S)		
				COUNTABLE			

PROMISSORY NOTES/DEEDS OF TRUST ☐ Y ☐ N BURIAL ☐ Y ☐ N PERSONAL PROPERTY ☐ Y ☐ N REAL PROPERTY ☐ Y ☐ N

MBR	TYPE	AMOUNT	ADDITIONAL EXPLANATION, VERIFICATION, CALCULATIONS	PROGRAM(S)		
			COUNTABLE			

VEHICLES ☐ Y ☐ N DMV ☐ MATCH ☐ NO MATCH DATE _____

MBR	YEAR, MAKE, MODEL	USE	FMV	FS LIMIT	EXCESS	LIEN	EQUITY	VERIFICATION, CALCULATIONS	PROGRAM(S)		
								COUNTABLE			

HEALTH INSURANCE ☐ Y ☐ N MEDICAID: HIPP APPLICATION, MEDICAL QUESTIONNAIRE COMPLETED ☐ Y ☐ N

MBR	TYPE	COMPANY	POLICY ID#	VERIFICATION	PREMIUM

LIFE INSURANCE ☐ Y ☐ N (NOT APPLICABLE FOR FOOD STAMPS) PROGRAM(S)

MBR	OWNER	TYPE	FACE $	CASH $	COMPANY, ACCT#	VERIFICATION			
						COUNTABLE			

6. TRANSFER OF RESOURCES ☐ Y ☐ N (MEDICAID: ALSO EVALUATE TRANSFER OF INCOME)

MBR	TYPE, DATE	VALUE	AMOUNT	VERIFICATION, CALCULATION OF PERIOD OF INELIGIBILITY	
					FS TANF MED

7. EARNED INCOME ☐ Y ☐ N PROGRAM(S)

MBR	INCOME SOURCE	DATE REC'D	AMOUNT	FREQUENCY	HRS/WK	VERIFICATION			
						COUNTABLE			

8. UNEARNED INCOME ☐ Y ☐ N PROGRAM(S)

MBR	INCOME SOURCE	DATE REC'D	AMOUNT	FREQUENCY	VERIFICATION			
					COUNTABLE			

VEC ☐ Match ☐ No Match Date _____ SVES ☐ Match ☐ No Match Date _____ APECS ☐ Match ☐ No Match Date _____

CALCULATIONS (DOCUMENT DISREGARDS, INCOME SCREENINGS, SELF EMPLOYMENT EXPENSES, SCHOOL EXPENSES, CHILD SUPPORT)

APPLICATION FOR OTHER BENEFITS: ( ) SSA ( ) SSI ( ) UCB ( ) VA ( ) OTHER _____

TOTAL COUNTABLE RESOURCES			
FS	TANF	MEDICAID	
$	$	$	$

TOTAL COUNTABLE INCOME			
FS	TANF	MEDICAID	
$	$	$	$

9. EXPENSES

SHELTER EXPENSES ☐ Y ☐ N

TYPE OF EXPENSE	MO. AMT.	VERIFICATION
RENT/MORTGAGE		
ELECTRICITY		
GAS/KEROSENE/COAL OIL/ WOOD		
WATER/SEWER		
GARBAGE		
INSTALLATION		
TAX/INSURANCE		

DAY CARE EXPENSES ☐ Y ☐ N CHILD SUPPORT DEDUCTION ☐ Y ☐ N

MBR	MO. AMT.	DESCRIPTION, VERIFICATION

MEDICAL EXPENSES ☐ Y ☐ N

MBR	MO. AMT.	DESCRIPTION, VERIFICATION, METHOD OF DEDUCTION

UTILITY STANDARD ☐ Y ☐ N ☐ 1-3 ☐ 4+ PHONE STANDARD ☐ Y ☐ N HOMELESS STANDARD ☐ Y ☐ N

REASON FOR ENTITLEMENT TO STANDARD:

10. GENERAL RELIEF (MAINTENANCE)

Period of Unemployment _____

Applied for SSI ☐ Decision appealed ☐

Release of SSI check signed _____

Modified Standard ☐ Full Standard ☐

Reason for Standard

11. EMERGENCY ASSISTANCE ( ) GR ( ) TANF-EA

Date and Reason for Emergency:

Assistance Previously Received? ☐ Y ☐ N

Date and Amount Received:

12. STATE AND LOCAL HOSPITALIZATION

MBR	Service Dates	Provider Name	Applied within 30 days?
			☐ Y ☐ N

13. DIVERSIONARY ASSISTANCE PROGRAM

Loss/Delay of Income ☐ Y ☐ N TANF Requirements Met? ☐ Y ☐ N

Emergency Need $ _____ Type _____

TANF $ _____ (Max 4 months) Payment $ _____ Date Issued _____

Vendor Payment Issued to: _____

TANF Period of Ineligibility: _____ to _____

Diversionary Assistance Ineligibility (60 mos.) Ends: _____

Acceptance Signed: ☐ Y ☐ N Date: _____

EVALUATION:

14. SPEND-DOWN CALCULATION

COUNTABLE INCOME	$ _____	$ _____	$ _____	SPEND-DOWN PERIOD: _____ FROM _____ TO
MINUS INCOME LEVEL	_____	_____	_____	Person(s) on Spend-down: _____
EXCESS INCOME	_____	_____	_____	Person(s) on Spend-down: _____

15. DISPOSITION

TEMPORARY ASSISTANCE PROGRAMS DATE GIVEN: BOOKLET _____ FOOD STAMPS HOTLINE _____ MEDICAID HANDBOOK _____

PROGRAM	DISPOSITION (Denial Reason)	EFFECTIVE DATE/ CERT/COVERED PERIOD	HH/AU SIZE	MONTHLY BENEFITS	PRORATED BENEFITS	SIGNATURE AND DATE (WORKER/SUPERVISOR)

EVALUATION OF ELIGIBILITY

FORM NUMBER - 032-03-823

PURPOSE OF FORM - To document verification of elements used to determine eligibility and to document eligibility decisions.

USE OF FORM - To be completed by the eligibility worker at application and review.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The form is to be kept in the case record.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the elements required for the program. If a sectional element is not appropriate for the program, it should be marked Not Applicable (NA). If an entire section does not apply, the section should be left blank.

The disposition section must be completed to summarize the eligibility decision. The form must be signed by the eligibility worker and should be signed by the supervisor, if a review of the action is completed.

Commonwealth of Virginia
Department of Social Services

PARTIAL REVIEWS AND CHANGES

CASE NAME	CASE NUMBER	FIPS

PROGRAM	ACTION DATE	EFFECTIVE DATE	REASON FOR REVIEW, METHODS AND DATES OF VERIFICATION	SIGNATURE AND DATE (Worker/Supervisor)

PROGRAM	ACTION DATE	EFFECTIVE DATE	REASON FOR REVIEW, METHODS AND DATES OF VERIFICATION	SIGNATURE AND DATE (worker/Supervisor

PARTIAL REVIEWS AND CHANGES

FORM NUMBER - 032-03-823B

PURPOSE AND USE OF FORM - To be completed by the eligibility worker to document changed information and partial eligibility evaluations.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The form is to be kept in the eligibility case record.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information for the case at the top of the form.

The eligibility worker must complete the form to record changed elements and to document the impact of the change(s) on the household's eligibility.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

FOOD STAMP PROGRAM – HOTLINE INFORMATION

NAME OF APPLICANT: _____

YOUR DATE OF APPLICATION: _____

THE DATE THE AGENCY MUST GIVE YOU YOUR FOOD STAMPS OR A DECISION: _____

☐ IF THIS BOX IS CHECKED, YOUR APPLICATION IS ENTITLED TO EXPEDITED SERVICE (7-DAY SERVICE)

If you don't get your food stamps or a decision by this date, you should call the Client Services Hotline for immediate help. The Hotline is open Monday through Friday, except holidays, from 8:15 a.m. to 5:00 p.m. The numbers are:

For the Richmond Calling Area: **692-2198**

For the Rest of Virginia: **1-800-552-3431**

Once you have called this number, you must be told by the next business day that you are either eligible or ineligible. If you are told that you are eligible, food stamps will be provided the next business day. However, if you call before 3:00 p.m. on Thursday or Friday and are eligible, food stamps will be provided on the next business day.

If you are not satisfied with the action the local agency took on your application, of if there are other problems with your Food Stamp case, you may contact the local legal aid office in your area. Names and addresses of legal aid offices are on the back of this flyer.

In order to determine if you are eligible for Food Stamps, the agency may ask you to verify certain information. If you have provided the required verifications, you should either have your food stamps or receive a denial notice within 30 days from the day you filed your application.

If you are in an emergency situation, you should have your food stamps within 7 days. This is called "expedited service." Your application will be given expedited service if:

- Your household's monthly income is less than $150, and resources are $100 or less; or
- Total income and resources are less than your shelter bills; or
- A migrant or seasonal farm worker lives in your household, and you have little or no income or resources.

_____ _____

NAME OF WORKER COMPLETING THIS FORM WORKER'S TELEPHONE

032-03-819/8 (08/03)

Blue Ridge Legal Services, Inc.
204 North High Street
Harrisonburg VA
(540) 433-1830
1-800-237-0141

Blue Ridge Legal Services, Inc.
119 South Kent Street
Winchester VA
540-662-5021
1-800-678-5021

Blue Ridge Legal Services, Inc.
203 North Main Street
Lexington VA
540-463-7334

Blue Ridge Legal Services, Inc.
132 Campbell Avenue, SW
Suite 300
Roanoke VA
540-344-2088
1-866-534-5243

Central VA Legal Aid Society
101 West Broad Street, Suite 101
Richmond VA
804-648-1012

Central VA Legal Aid Society
617 W. Main Street, 2nd Floor
Charlottesville VA
(434) 296-8851
1-800-390-9983

Central VA Legal Aid Society
10-A Bollingbrook
Petersburg VA
804-862-1100

Eastern VA Legal Aid Society
125 St. Paul's Boulevard
Norfolk VA
757-627-5423
1-800-868-1072

Legal Aid Justice Center
1000 Preston Avenue, Suite A
Charlottesville VA
(434) 977-0553
1-800-578-8111

Legal Aid Society of Roanoke Valley
416 Campbell Avenue SW
Roanoke VA
(540) 344-2088
1-800-711-0617

Legal Services of Eastern VA
2017 Cunningham Dr. Suite 300
Hampton VA
757-827-2912
1-800-944-6624

Legal Services of Eastern VA
199 Armistead Avenue
Williamsburg VA
757-220-6837
1-800-455-8208

Legal Services of Eastern VA
36314 Lankford Highway, Suite 5
Belle Haven VA
757-442-3014
1-800-455-8208

Legal Services of Northern VA
6400 Arlington Boulevard
Suite 630
Falls Church VA
703-532-3733

Legal Services of Northern VA
603 King Street, 4th Floor
Alexandria VA
703-684-5566

Legal Services of Northern VA
1916 Wilson Boulevard, Suite 200
Arlington VA
(703) 532-3733

Legal Services of Northern VA
4080 Chain Bridge Road
Fairfax VA
703-246-4500

Legal Services of Northern VA
204 Wirt Street, SW
Leesburg VA
703-777-7450

Legal Services of Northern VA
9240 Center Street
Manassas VA
703-368-5711

Rappahannock Legal Services, Inc.
910 Princess Anne Street
Fredericksburg VA
540-371-1105

Rappahannock Legal Services, Inc.
314 North West Street
Culpeper VA
540-825-3131

Rappahannock Legal Services, Inc.
P.O. Box 1662
Tappahannock VA
(804) 443-9393
1-800-572-3094

Southwest VA Legal Aid Society, Inc.
155 Arrowhead Trail
Christiansburg VA
540-382-6157
1-800-468-1366

Southwest VA Legal Aid Society, Inc.
227 West Cherry Street
Marion VA
(276) 783-8300
1-800-277-6754

Southwest VA Legal Aid Society, Inc.
P.O. Box 670
Castlewood VA
(276) 762-9356
1-888-201-2772

Virginia Legal Aid Society
513 Church Street
Lynchburg VA
804-528-4722
1-800-552-7676

Virginia Legal Aid Society
105 S. Union Street, Suite 400
Danville VA
804-799-3550
1-800-552-7676

Virginia Legal Aid Society, Inc.
104 High Street
Farmville VA
804-392-8108
1-800-552-7676

Virginia Legal Aid Society, Inc.
112 W. Washington Street, Suite 300
Suffolk VA
757-539-3441
1-800-552-7676

Virginia Legal Aid Society, Inc.
412 South Main Street
Emporia VA
804-634-5172
1-800-552-7676

Legal Aid Justice Center
1000 Preston Avenue, Suite A
Charlottesville VA
(434) 296-8851
1-800-200-8479

Legal Services Corp. of Virginia
700 E. Main Street, Suite 1504
Richmond, VA
(804) 782-9438

Virginia Poverty Law Center, Inc.
201 W. Broad Street, Suite 302
Richmond, VA
(804) 782-9430
1-800-868-8752

FOOD STAMP PROGRAM - HOTLINE INFORMATION

FORM NUMBER - 032-03-819

PURPOSE AND USE OF FORM - To inform each household of the timeframe the agency has to process its application.

NUMBER OF COPIES - One.

DISPOSITION OF FORM – The agency must complete the form and give it to the household on the day of application for **benefits for any period for which the household has not already received benefits, i.e., new application, reapplication, or late recertification. The agency must mail the form if the household filed the application by mail.**

INSTRUCTIONS FOR PREPARATION OF FORM -

The local agency must complete all blanks on the form.

Enter the name of the person filing the application at “Name of

Enter the date the household filed the application at “Your Date of

At "The Date the Agency Must Give You Your Food Stamps or Decision," enter the date that is 30 days from the date of application, unless the applicant is entitled to expedited service. If expedited service is appropriate, the date for this blank will be 7 days from the application date.

If the application is expedited, the worker checks the block indicating that entitlement.

Enter the information requested at “Name of Worker Completing This Form.”

The worker must circle the name and number of the legal aid office serving the locality on the back of the flyer.

DEPARTMENT OF SOCIAL SERVICES
FOOD STAMP PROGRAM

KNOW YOUR RIGHTS WHEN APPLYING FOR FOOD STAMPS

If you are interested in applying for Food Stamps, here is information you need to know:

Persons applying for Food Stamps must file an application by submitting the application form to the Department of Social Services in the county or city where they live, either in person, through an authorized representative, or by mail.

You have the right to file an application on the same day you contact the Department of Social Services in your locality. The address and hours of the office are shown at the bottom of this notice. Your application may be submitted any time during office hours.

You may come to the office to pick up an application any time during office hours, or the agency can mail you an application on the same day you request it.

If your resources and income are very low ($100 in resources and $150 in income), or you are a migrant or seasonal farmworker, or your combines gross monthly income and resources are less than your family's shelter expenses, you may be eligible for expedited service. This means that if you are eligible, you are entitled to receive food stamps within 7 days following the date your application is filed at the local social services department.

Your Application will be reviewed on the day it is received for possible eligibility for expedited service.

You have the right to file an application even if you appear to be ineligible for the program.

You or a designated authorized representative may file an incomplete application as long as it contains a name, address, and signature of a responsible household member or properly designated authorized representative. The agency has 30 days to process your application (7days, if expedited). The 30-day (or 7-day, if expedited) processing time begins the day after the application is received at the office. Additionally, your food stamp benefits for the month of application will be prorated from the date of application if you are found eligible.

If your case is approved, you must receive your benefits within 30 days following the date of application (or 7 days, if expedited)

As part of the Food Stamp application process, you will be required to have an in-office interview before being certified, but the interview is not necessary before filing an application. Under certain hardship conditions, you may request the office interview be waived and replaced, for example, by a telephone interview.

The Food Stamp Program has separate rules and processes from other programs. You should apply for food stamps even if there are limitations on receiving benefits for other programs.

YOU ARE ENCOURAGED TO APPLY FOR FOOD STAMPS THE SAME DAY YOU CONTACT THE AGENCY FOR ASSISTANCE.

AGENCY NAME:

ADDRESS:

PHONE NUMBER:

OFFICE HOURS:

The Food Stamp Program is administered without regard to age, race, color, sex, disability, religious creed, national origin, or political beliefs. The Virginia Department of Social Services is an equal opportunity provider.

KNOW YOUR RIGHTS WHEN APPLYING FOR FOOD STAMPS

FORM NUMBER - 032-03-821

PURPOSE OF FORM - To consolidate information the local agency must share with an applicant for food stamps. The Form's use is optional.

USE OF FORM - May be given to applicants requesting food stamp program information instead of a verbal explanation of applicants' rights. The agency must advise applicants that the form is a listing of program rights. The agency must also ensure that the applicant is able to read the form in English and comprehend it.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The flyer may be given to applicants inquiring about the Food Stamp Program.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the bottom of the form, supplying the local agency's name, address, telephone number, and office hours.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
FOOD STAMP PROGRAM

EXPEDITED SERVICE CHECKLIST

NAME: _____

DATE: _____

I. ( ) YES ( ) NO Has anyone for whom you are applying received food stamps this month?

If YES, who: _____

where: _____

II. INCOME BEFORE DEDUCTIONS this month for everyone in your household. Count money already received plus any money expected to be received during this month.

Type of Income

_____ $_____

_____ $_____

III. RESOURCES for everyone in your household:

Cash on Hand $_____
Checking Accounts $_____
Savings Accounts $_____

IV. SHELTER EXPENSES this month. Do not count amounts due for previous months:

Rent/Mortgage $_____
Electricity $_____
Gas, Oil, Kerosene, Wood $_____
Water, Sewer $_____
Garbage $_____
Telephone (count basic service only) $_____

V. ( ) YES ( ) NO Is anyone in your household a Migrant or a Seasonal Farmworker?

AGENCY USE ONLY

1. ( ) YES ( ) NO Is income less than $150 AND resources $100 or less?

IF YES, EXPEDITE

2. . ( ) YES ( ) NO Is income plus resources less than shelter?

Income $_____
Resources +$_____
Total $_____

Shelter $_____

IF YES, EXPEDITE

NOTE: If the household is entitled to the Utility Standard, the Standard may be used to determine Shelter, unless the household chooses to use actual shelter costs.

FOR MIRGRANT & SEASONAL FARMWORKERS

3A. ( ) YES ( ) NO Are resources $100 or less AND, in the next 10 days, $25 or less is expected from new income source?

IF YES, EXPEDITE

3B. ( ) YES ( ) NO Are resources $100 or less AND no income is expected from a terminated source this month or next month?

IF YES, EXPEDITE

DETERMINATION

( ) EXPEDITED ( ) NOT EXPEDITED

Screened by:

EXPEDITED SERVICES CHECKLIST

FORM NUMBER - 032-03-718

PURPOSE OF FORM - To assist agencies in screening households for entitlement to expedited services.

USE OF FORM - To be completed, as needed, at the time of **a new** application, reapplication **or a late recertification** to identify households who are eligible for expedited services.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - File in the case record.

INSTRUCTIONS FOR PREPARATION OF FORM – Obtain the information on the left side of the form from the applicant. The applicant, eligibility worker, screener, volunteer, or anyone else designated by the agency, may complete the left side of form.

Agency personnel must complete the "Agency Use Section". The form identifies each of the ways a household could be eligible for expedited service. If a household is entitled to expedited services, the EW must conduct an interview and authorize benefits within the expedited service time frames. Note however, that the interview may be postponed under certain circumstances.

NOTE: This form was developed to assist in screening households for expedited services. Agencies which use appointment systems for interviews must screen all applicants to ensure that those entitled to expedited services are given appointments and delivered benefits within expedited time frames. Agencies which interview clients on a walk-in, daily basis may not necessarily need to use this checklist, since determination for expedited service can be made during the interview.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

CHECKLIST OF NEEDED VERIFICATIONS

Name Address	Case Number	
	Program(s)	Date
	Worker	Telephone

In order to receive assistance, you must provide the information checked below. We will help you obtain the information. If you cannot provide the information, or if you need help in providing the information, contact your worker. Call collect, if necessary. IF YOU DO NOT PROVIDE THIS INFORMATION OR CONTACT THE AGENCY BY THE FOLLOWING DATES, YOUR APPLICATION MAY BE DENIED. TANF: _____ FOOD STAMPS:_____ MEDICAID:_____ OTHER:_____

1. INCOME (Earned and Unearned) for _____
( ) Pay stubs
( ) Statement from employer
( ) Self-employment records
( ) Social Security/SSI benefits
( ) VA benefits
( ) Retirement income
( ) Child support, alimony payments
( ) Unemployment benefits
( ) Worker's Compensation benefits
( ) Loans (personal or education)
( ) Scholarships, (BEOG, PELL SEOG, CSAP, or other)
( ) Work-study pay stubs
( ) Other _____

2. WORK OR SCHOOL EXPENSES
( ) Day care expenses for child or adult
( ) School expenses (tuition, fees, books supplies, transportation, or other)
( ) Other _____

3. RESOURCES
( ) Checking, savings, credit union, Christmas Club account statements
( ) Stocks, bonds or CDs
( ) Pension plans, retirement accounts, IRAs
( ) Burial plots, funds, contracts
( ) Real estate property
( ) Title, registration, or personal property tax receipt for motor vehicles, motor boats, motor homes
( ) Life insurance policies
( ) Other _____

4. SHELTER EXPENSES
( ) Rent or mortgage receipt
( ) Real estate taxes
( ) Homeowner's insurance
( ) Electric bill
( ) Gas.Kerosene/oil/wood bill
( ) Water/sewage bill
( ) Garbage bill
( ) Phone bill
( ) Initial installation charge
( ) Other_____

5. LEGALLY RESPONSIBLE RELATIVE
( ) Income verification
( ) Statement of contribution
( ) Child support or alimony
( ) Extraordinary expenses
( ) Proof of continued absence
( ) Copy of support order
( ) Other _____

6. WORK REGISTRATION
( ) Registration form

7. IDENTITY
( ) Driver's license
( ) Voter registration card
( ) Clinic, medical card
( ) Work ID, school ID, library card
( ) Other _____

8. RESIDENCY, LIVING ARRANGEMENTS, SCHOOL ENROLLMENT
( ) Verification of residence
( ) Verification of child(ren) living in the home
( ) School enrollment
( ) Separate arrangements to buy and prepare food
( ) Other _____

9. DOCUMENTS
( ) SSN Cards/numbers
( ) Application for SSN card
( ) Declaration of citizenship
( ) Immigrant/Alien documentation
( ) Birth verification
( ) Verification of paternity
( ) Marriage certificate
( ) Divorce decree
( ) Death certificate
( ) Deprivation statement
( ) Other _____

10. MEDICAL INFORMATION
( ) Assignment of Rights form
( ) Medical form, statements
( ) Pregnancy statement
( ) Health insurance policies, cards
( ) Medicare card
( ) Health insurance premiums
( ) Medical bills for _____ _____
( ) Prescription drug bills
( ) HIPP forms
( ) Immunization records
( ) Other _____

Other information or verification needed:_____

_____

_____

_____

CHECKLIST OF NEEDED VERIFICATIONS

FORM NUMBER - 032-03-814

PURPOSE OF FORM - To advise households of verifications needed to process their applications.

USE OF FORM - To be completed by the eligibility worker and given to the applicant to meet the requirement that households receive written notice of verification requirements. The form is required for Food Stamps. It may be used to inform applicants of verifications needed for other programs.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is given to the household. The agency retains a copy with the food stamp application and a copy may be filed with applications for other benefits.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form. Complete the sentence "Please provide information by: _____" with the date by which verification is needed. For an initial application or reapplication for food stamps, this date would be **10** days from the date of application. For a recertification application, this date would be 10 days from the interview date or other date when the household was told what was needed. **No action may be taken to deny the application before the 30th day after the filing date if verifications are not provided by the 10th day.**

In the body of the form, check the items requiring verification.

Use the blank lines at the bottom of the form for additional information or instructions. For example, for expedited applications, information not available during the interview can be noted with instructions to submit the information within **seven** days following the application date. The form must still indicate the verifications needed for normal processing however.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
FOOD STAMP PROGRAM

NOTICE OF ACTION

THIS IS TO INFORM YOU OF ACTION TAKEN ON YOUR FOOD STAMP APPLICATION CASE.

CASE NUMBER
DATE
COUNTY/CITY

[ ]

[ ]

SECTION 1. ACTION ON APPLICATION DATED _____

❑ Approved for following months _____
Amount first month $_____ Month covered _____ Amount for following months $_____
You selected _____ as Head of Household. If all adult members do not agree, contact your worker in 10 days.
NOTE: If you applied for both Food Stamps and TANF or GR at the same time, and then are approved for TANF or GR benefits, your food stamp amount may be reduced without advance notice.

- ❑ If this box is checked, your application was approved even though some verification was postponed. We need the following information or verification from you: _____
  _____
  If we do not receive these by _____ your case will be closed effective _____
  If this verification results in changes in your household's eligibility or amount of benefits, we will make such changes without advance notice.

❑ Denied. See Section 3

❑ Continue to hold application pending. The cause for delay is:

- ❑ Agency delay. Your application will be processed as soon as possible.
- ❑ Client delay.
- ❑ We are waiting for the following information from you:_____
  We must have this information by _____ or your application will be denied.

SECTION 2. ACTION ON FOOD STAMP CASE

❑ Changed from $ _____ to $_____ effective _____

- ❑ If this box is checked, we must receive the following verification from you:_____
  _____
  We must receive this verification by _____ If you allotment was increased but we do not receive this verification, you benefits will go back to the amount $_____ effective _____ without advance notice.

❑ Reinstated – Amount $_____ effective _____

❑ Supplemented – Amount $_____ for the month of _____

❑ Suspended for the month of _____

❑ Terminated effective _____

SECTION 3. ACTION ON FOOD STAMP CASE

YOU MUST REPORT WITHIN 10 DAYS REQUIRED CHANGES IN THE PERSONS IN YOUR HOUSEHOLD AND IN YOUR FINANCIAL SITUATION. If necessary, you may call collect.

Children approved for food stamp benefits and attending public school may be eligible for free meals. Call your school for more information.

Food stamps or an ATP card not received in the mail or destroyed after receipt may be replaced if the loss is reported right away.

If you do not agree with the action we have taken or the amount of food stamp you are receiving, you can have a fair hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake, and a hearing officer will decide if you are right. To request a fair hearing, you may call me at the number below or write to the Virginia Department of Social Services, Attention: Manager, Appeals and Fair Hearings, 730 East Broad Street, Richmond, Virginia 23219-1849. You may also request a fair hearing by calling toll free 1-800-552-3431. You must request your hearing within the next 90 days. If you appeal the action on your case before _____ assistance may continue. However, if assistance is continued, you may have to repay food stamp benefits you received during the appeal process if the hearing decision supports the agency action. For additional information about appeals and fair hearings, please see the back of this notice.

Worker	Telephone Number	For Free Legal Advice Call

032-03-117/14 (12/97)

CLIENT

APPEALS AND FAIR HEARINGS

A fair hearing provides you the opportunity to review the way a local agency social services agency has handled your situation concerning your stated need for food stamps. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services.

In addition to filling an appeal, you also have the right to request a conference with your local social services agency, at which time the agency must give you an explanation of its proposed action. You must also be given the opportunity to present any information on which your disagreement with the agency's proposed action is based. At such a conference, you have the right to have your story presented by an authorized representative, such as a friend, relative or lawyer.

If you request the conference within 10 days of receipt of your advance notice of proposed action to decrease or terminate your food stamp benefits, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the local social services agency's action following the conference, and you want to request that your food stamp benefits be continued as usual until a hearing decision is received, you must file an appeal within two days following the date of the conference. If you do not request a conference but file your appeal within 10 days of your advance notice of proposed action to decrease or terminate your food stamp benefits, your benefits may be continued until a hearing decision is reached. However, if the agency's action is upheld, you will be required to repay the food stamp benefits received during the appeals process.

If you wish to request a hearing, follow the instructions on the front of this form.

The person who conducts the hearing is someone from the State Department of Social Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call your eligibility worker immediately. If you need transportation, the local agency will provide it. You may bring a representative and/or witnesses to the hearing to help you tell your story. Your eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

(1) examine all documents and records which are used at the hearing;

(2) present your case or have it presented by a lawyer or by another authorized representative;

(3) bring witnesses;

(4) establish pertinent facts and advance arguments; and

(5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 60 days of the date your appeal request is received by the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency, consequently, if you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

NOTICE OF ACTION

FORM NUMBER - 032-03-117

PURPOSE OF FORM - To notify an applicant/recipient of eligibility action taken on an application or an ongoing food stamp case.

USE OF FORM - To be prepared and sent immediately or within the appropriate time standard following action on an application or a food stamp case.

The Notice of Action may be used in place of the Advance Notice of Proposed Action for food stamp only cases. It is to be used in all instances where policy requires the use of an "adequate notice".

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The original is to be forwarded to the head of the household. One (1) copy is to be retained in the case file.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form.

SECTION 1
Use this section to inform the household of the disposition of an application, reapplication or recertification.

Enter the date of the application.

Check the appropriate box to show the disposition of the application.

For approvals, indicate the months of certification, the allotment and months covered by the first issuance, and the amount for following months.

If the application was expedited and verification was postponed, check the box which says "If this box is checked...." List the postponed verification, the date by which the verification is needed, and the effective date of closure if the verification is not received. The deadline date for submitting the verifications will be the 30th day after the application filing date and the closure date will be the last day of the month of

application for applications filed before the 15th day of the month. For applications filed on or after the 16th day of the month, the verification deadline and closure date will be the last day of the month after the month of application.

For applications which must be held pending an additional 30 days, check whether the delay was caused by the agency or household. If information is still needed, indicate the missing information and date by which information is needed to prevent denial.

SECTION 2
Use this section to inform the household of action taken on an ongoing food stamp case.

Check the appropriate box to show a change in an allotment, a reinstatement, a supplement, a termination or a suspension. An "other" block is also provided for situations that may not be covered by the choices listed.

If verification is needed of a change, check the indented block which explains that verification must be received or the allotment will revert to the previous amount. Complete blanks as needed for the specific situation.

SECTION 3
Use this section to explain the reason for the action taken or to give a further explanation of any of the items checked in Sections 1 or 2.

Complete the information at the bottom of the form. **A date must be entered in the space provided in the appeal information section whenever the form is sent for negative actions to reduce, terminate, or to suspend benefits. A date must not be entered when the form is sent for approvals or denials of applications.**

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

ADVANCE NOTICE OF PROPOSED ACTION

CASE NUMBER	PROGRAM

DATE OF MAILING:

IF YOU WANT FREE LEGAL ADVICE, CALL: _____
THIS NUMBER IS A LOCAL LEGAL SERVICES AGENCY, NOT THE DEPARTMENT OF SOCIAL SERVICES.

ACTION TO BE TAKEN ON YOUR CASE IS EXPLAINED BELOW.

☐ **FOOD STAMPS** YOUR FOOD STAMP ALLOTMENT WILL BE: ☐ REDUCED ☐ SUSPENDED ☐ TERMINATED

EFFECTIVE DATE:	AMOUNT OF REDUCTION: FROM: TO:	ELIGIBILITY WORKER:	TELEPHONE:

REASON FOR PROPOSED ACTION: _____

☐ **FINANCIAL ASSISTANCE** YOUR ASSISTANCE CHECK WILL BE: ☐ REDUCED ☐ SUSPENDED ☐ TERMINATED

EFFECTIVE DATE:	AMOUNT OF REDUCTION: FROM: TO:	ELIGIBILITY WORKER:	TELEPHONE:

MANUAL REFERENCE: _____ REASON FOR PROPOSED ACTION: _____

☐ VIEW TERMINATION - THE TANF CASE IS CLOSED UNTIL YOU REAPPLY AND ARE FOUND ELIGIBLE FOR TANF/TANF-UP
☐ VIEW SANCTION - YOUR HOUSEHOLD'S ENTIRE TANF OR TANF-UP BENEFITS WILL BE SUSPENDED FOR THE ABOVE REASON.
☐ 1ST SANCTION - 1 MONTH OR COMPLIANCE ☐ 2ND SANCTION - 3 MONTHS AND COMPLIANCE ☐ 3RD SANCTION - 6 MONTHS AND COMPLIANCE
YOU HAVE 10 DAYS AFTER THE DATE OF THIS NOTICE TO CONTACT YOUR VIEW WORKER TO SHOW DOCUMENTED GOOD CAUSE.

VIEW WORKER'S NAME _____ TELEPHONE: _____

☐ WHILE YOUR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PAYMENT IS SUSPENDED, ANY SUPPORT PAID TO THE DIVISION OF CHILD SUPPORT ENFORCEMENT FOR YOU OR YOUR DEPENDENTS WILL BE KEPT BY THE STATE TO REPAY THE PAST TANF ASSISTANCE RECEIVED BY YOUR FAMILY. IF YOUR TANF DEBT HAS BEEN FULLY REPAID, YOU WILL RECEIVE THE SUPPORT COLLECTED.

☐ IF THERE IS SOMEONE WHO IS SUPPOSED TO PAY SUPPORT FOR YOU OR YOUR DEPENDENTS, YOU WILL CONTINUE TO RECEIVE SUPPORT ENFORCEMENT SERVICES UNLESS YOU SEND WRITTEN NOTICE THAT YOU DO NOT WANT THIS SERVICE TO THE DIVISION OF CHILD SUPPORT ENFORCEMENT. YOU CAN OBTAIN THEIR ADDRESS AND TELEPHONE NUMBER FROM YOUR LOCAL SOCIAL SERVICES AGENCY.

☐ **MEDICAID, FAMIS PLUS OR STATE/LOCAL HOSPITALIZATION (SLH)**

☐ NO LONGER ELIGIBLE FOR FULL MEDICAID. APPROVED FOR LIMITED MEDICAID COVERAGE:
QMB _____ SLMB _____ QI1 _____
☐ NO LONGER ELIGIBLE FOR MEDICAID. ☐ NO LONGER ELIGIBLE FOR FAMIS PLUS. ☐ NO LONGER ELIGIBLE FOR SLH.
☐ NO LONGER ELIGIBLE FOR PAYMENT OF LONG-TERM CARE BECAUSE OF TRANSFER OF ASSETS.

EFFECTIVE DATE	MANUAL REFERENCE:	ELIGIBILITY WORKER:	TELEPHONE:

INELIGIBLE FAMILY MEMBERS:

REASON FOR PROPOSED ACTION:
☐ INCOME EXCEEDS THE FULL MEDICAID LIMIT. IF MEDICAL OR DENTAL EXPENSES OF $ _____ ARE INCURRED BETWEEN _____ AND _____ OR MEDICAL OR DENTAL EXPENSES OF $ _____ ARE INCURRED BETWEEN _____ AND _____, BRING YOUR BILLS TO THIS AGENCY AND YOUR ELIGIBILITY WILL BE REVIEWED.
☐ OTHER: _____

IF YOU DISAGREE WITH THE PROPOSED ACTION, YOU MAY WRITE OR CALL YOUR WORKER AND ASK FOR A CONFERENCE, OR YOU MAY REQUEST IN WRITING A FAIR HEARING TO APPEAL THE ACTION. FOOD STAMP AND TANF ACTIONS MAY ALSO BE APPEALED ORALLY. AT THE HEARING, YOU WILL HAVE A CHANCE TO EXPLAIN WHY YOU THINK WE MADE A MISTAKE AND A HEARINGS OFFICER OR APPROPRIATE AUTHORITY WILL DECIDE IF YOU ARE RIGHT.

IF YOU APPEAL THE PROPOSED ACTION ON YOUR GENERAL RELIEF, AUXILIARY GRANT, OR FOOD STAMP CASE BEFORE _____, ASSISTANCE MAY CONTINUE. IF YOU APPEAL THE PROPOSED ACTION ON YOUR TANF, REFUGEE ASSISTANCE, MEDICAID, FAMIS PLUS OR SLH CASE BEFORE _____, ASSISTANCE MAY CONTINUE. IF THE HEARING DECISION SUPPORTS THE ACTION BEING PROPOSED BY THE AGENCY, YOU MAY HAVE TO REPAY ASSISTANCE YOU RECEIVED DURING THE APPEAL PROCESS. YOU MAY WAIVE YOUR RIGHT TO CONTINUED ASSISTANCE BY SUBMITTING A WRITTEN STATEMENT TO YOUR ELIGIBILITY WORKER INDICATING YOUR DESIRE TO REFUSE SUCH ASSISTANCE. AN APPEAL CAN BE FILED FOR GENERAL RELIEF AND AUXILIARY GRANT CASES FOR UP TO 30 DAYS AFTER RECEIPT OF THIS NOTICE AND FOR FOOD STAMPS FOR UP TO 90 DAYS. FOR TANF, REFUGEE ASSISTANCE, MEDICAID, FAMIS PLUS OR SLH, AN APPEAL CAN BE FILED FOR UP TO 30 DAYS AFTER RECEIPT OF THIS NOTICE IF THE PROPOSED ACTION IS EFFECTIVE WITHIN THE NEXT 30 DAYS. IF THE PROPOSED ACTION IS EFFECTIVE MORE THAN 30 DAYS FOLLOWING RECEIPT OF THIS NOTICE, AN APPEAL MAY BE FILED UNTIL THE EFFECTIVE DATE.

NOTE: FOR ADDITIONAL INFORMATION ABOUT APPEALS AND FAIR HEARINGS, REFER TO THE BACK OF THIS FORM.

032-03-018/27 (6-04)

APPEALS AND FAIR HEARINGS

SEND WRITTEN APPEALS TO THE ADDRESSES BELOW. YOU MAY ALSO FILE A FOOD STAMP OR TANF APPEAL ORALLY BY CALLING YOUR LOCAL AGENCY OR DIALING TOLL FREE 1-800-552-3431.

FINANCIAL ASSISTANCE AND FOOD STAMP APPEALS SHOULD BE SENT TO:

HEARINGS AND LEGAL SERVICES MANAGER
VIRGINIA DEPARTMENT OF SOCIAL SERVICES
7 NORTH EIGHTH STREET
RICHMOND, VA 23219-3301

MEDICAID, FAMIS PLUS, AND SLH APPEALS SHOULD BE SENT TO:

CLIENT APPEAL DIVISION
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for financial assistance, Medicaid, FAMIS Plus, SLH, and/or food stamps. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearings officer. The hearings officer is the official representative of the State Department of Social Services or the Department of Medical Assistance Services.

In addition to filing an appeal, you have the right to request a conference with your local social services agency, at which time the agency must give you an explanation of its proposed action. You must also be given the opportunity to say why you disagree with the agency's proposed action. At the conference, you have the right to have your story presented by an authorized representative, such as a friend, relative or lawyer.

If you request the conference within 10 days of receipt of your Advance Notice of Proposed Action to decrease, suspend or terminate your services, financial assistance or food stamps, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the local social services agency's action following the conference, and you want to request that your financial assistance be continued as usual until a hearing decision is received, you must file an appeal within two days following the date of the conference. You must request the appeal within 10 days of the conference date for Food Stamps. If you do not request a conference but file your appeal within 10 days of your advance notice of action to reduce, suspend, or terminate your services, financial assistance or food stamps, your benefits may be continued until a hearing decision is reached. If you appeal the proposed action on your TANF, Refugee Assistance, Medicaid or FAMIS Plus case prior to the reduction, suspension, or termination effective date, you may also receive continued assistance. However, if the agency action is upheld, you will be required to repay assistance received during the appeal process.

If you request an appeal concerning food stamps, the local social services agency must offer you a conference after your appeal is filed.

The person who conducts the hearing is someone from the State Department of Social Services or the Department of Medical Assistance Services, not someone from your local social services agency. The hearings officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your service or eligibility worker immediately. If you need transportation, the local agency will provide it. You may bring a representative and/or witnesses to the hearing to help you tell your story. Your service or eligibility worker, a local agency supervisor and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

(1) Examine all documents and records that are used at the hearing;

(2) Present your case or have it presented by a lawyer or by another authorized representative;

(3) Bring witnesses;

(4) Establish pertinent facts and advance arguments; and

(5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision of the hearings officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearings officer's decision on your appeal within 60 days of the date your appeal request is received by the State Department of Social Services. If the decision is based on a Medicaid, FAMIS Plus or SLH appeal, you will be notified in writing within 90 days of the date your appeal is received by the Department of Medical Assistance Services.

ADVANCE NOTICE OF PROPOSED ACTION

FORM NUMBER - 032-03-018

PURPOSE OF FORM - (1) To notify a household of a reduction, termination or suspension of benefits which occurs within the certification period; and, (2) to advise the household of its right to a local agency conference and its right of appeal to the State agency.

USE OF FORM - (1) To be prepared immediately following the decision of the local agency that the above action is indicated; and, (2) to be mailed to the recipient immediately or as soon as possible after such decision.

This form may be used to advise recipients of simultaneous decreases or terminations in more than one program. Mandates for joint use in Public Assistance and Food Stamps are contained in Part XIV.A.3. of this manual and in Section 401.4 of the AFDC Manual.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is to be issued to the head of the household. One (1) copy is to be retained in the food stamp case file and one (1) copy is to be placed in another program file, if appropriate.

INSTRUCTIONS FOR PREPARATION OF FORM - Enter the appropriate identifying information at the top of the form. The name and mailing address of the recipient are to be inserted in the space at the top of the form, spaced in such a way that a window envelope can be used for mailing. Enter all the case numbers and categories related to the proposed action.

For each program section, enter, as appropriate:

a. Action Type

b. Reason for Proposed Action

c. Manual Reference

d. Worker's Name and Telephone Number

e. Amount of Reduction - Enter the former and new assistance or allotment amounts.

f. Effective Date - Enter the date of the proposed action. This date must be at least 11 days after the date the form is mailed.

Examples

(1) An Advance Notice of Proposed Action is mailed on October 15; the effective date of proposed action would be November 1.

(2) An Advance Notice of Proposed Action is mailed on October 25; the effective date, if check is issued the first of each month, would be December 1.

MEDICAID SECTION -

a. When it is established that a recipient, or any member of a recipient's family unit, is ineligible for Medicaid, for reasons other than income in excess of the established amount:

1) Enter the effective date of the proposed action.

2) Ineligible Members - Enter the names of all ineligible individuals.

b. When it is established that an otherwise eligible recipient, or family unit, is ineligible due to income in excess of the established amount:

1) Enter the amount of the excess income which must be spent or incurred in medical expenses before eligibility can be established.

2) Enter the date which identifies the end of the appropriate six-month spend down which begins the first day of the month of termination.

APPEALS -

a. For Food Stamp and Financial Services actions, enter the date that is 11 days after the date of mailing to indicate the date before which a timely appeal can be filed.

For Medicaid actions, enter the effective date of the proposed action to indicate the date before which a timely appeal can be filed.

b. Enter the effective date of the proposed action.

c. Enter the address of the local agency, the date of mailing, and the telephone number of the local legal aid representative, if any.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

FOOD STAMP PROGRAM
NOTICE OF EXPIRATION

FOOD STAMP CASE NUMBER
COUNTY / CITY
DEPARTMENT OF SOCIAL SERVICES
ADDRESS
CITY, STATE, ZIP
TELEPHONE NUMBER

TO:

YOUR FOOD STAMP CERTIFICATION WILL END ON (MO., DAY, YR.)

In order to receive uninterrupted benefits after your current certification ends, you must file a new application by_____(Mo./Day/Yr.) and be found eligible based on the information given for this application. The application may be completed during the interview in our office. You may also request an application form to complete yourself or have it completed for you prior to your interview. The application must contain a name, address and signature. An interview in our office is required. (If this is impossible, please call and we will make special arrangements for you.) We can only begin processing your request for continued certification when you come in for your interview or we receive your application form. The application form may be filed in person, by mail, by fax, or by your authorized representative at the address given above or below. If you fail to come in for your interview or file an application by the specified date, you cannot be assured of continued participation without interruption.

We have arranged an appointment for an interview on_____ at the address above, unless an alternate address is listed below. If you miss this or any interview scheduled by the local social services agency for your food stamp application, it will be your responsibility to reschedule it. It will also be necessary for you to provide your eligibility worker with proof of your income and expenses and other information if requested in order to receive uninterrupted benefits.

If you do not agree with the action taken on your application, you have the right of appeal. If you decide to appeal, you must do so within ninety days after being informed of this department's decision. You may get an appeal form from this department or from the State Department of Social Services, 730 East Broad Street, Richmond, VA 23219-1849, or you may file your appeal by calling toll free 1-800-552-3431.

If all members of your household are now receiving Supplemental Security Income (SSI) or plan to apply for SSI, you may reapply for food stamps at the social security (SSA) office instead of filing your application at the local social services department. If you choose to do this, the social security office must also receive your application by the date indicated above. SSA will send the application on to the food stamp office for recertification processing.

The Virginia Department of Social Services is an equal opportunity provider.

ALTERNATE AGENCY ADDRESS:

SIGNATURE OF ELIGIBILITY WORKER	DATE	☐ MAILED ☐ GIVEN

NOTICE OF EXPIRATION

FORM NUMBER - 032-12-157 (Manual version 032-03-157)

PURPOSE OF FORM - To advise the household (1) that its certification period is about to expire; and, (2) that a new application is necessary to establish further entitlement.

USE OF FORM - Households approved in the last month of their certification period, i.e., households certified retroactive to a previous month(s), must have the expiration notices at the time of certification. All other households must have the expiration notices no later than the last day of the next to the last month of the current certification period, but not earlier than the first day of the next to the last month of the current certification period. When the agency mails the Notice of Expiration, allow two days for delivery in addition to the postmark date. The Notice of Expiration will run on the 8th of the month. If the 8th is on a weekend or holiday, the Notice of Expiration will run on the last working day before the weekend or holiday.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The agency must give or mail the original Notice of Expiration to the head of the household. One (1) copy remains in the case file.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete all blanks.

Below the agency's address enter the date the certification period will end, which is the last day of the last month of certification, in the space provided. Enter an alternate address for the agency at the bottom of the form, if appropriate.

Enter the date by which the household must file an application for recertification. For households approved in the last month of their certification period, this will be 15 calendar days from the date the notice will be received. (Allow two days for mailing in addition to the postmark date.) For all other households, this will be the 15th calendar day of the last month of certification.

Indicate whether the agency mailed or gave the form to the recipient on the date indicated.

Enter information regarding an interview date and time.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

CHANGE REPORT

CASE NAME	CASE NUMBER
WORKER NAME	LOCALITY
AGENCY TELEPHONE NUMBER	

Use this form or call your worker to report changes listed below for your Food Stamps or Temporary Assistance for Needy Families (TANF) case.

Report changes within 10 days of the day they occur; but at the latest, you have until the 10th day of the following month to report the change.

Note: If you have a Medicaid case, you must report **all** changes to your Medicaid worker within 10 days.

ADDRESS CHANGE

New Address (Street, Apt. Number)	City, State Zip	Telephone

GROSS INCOME FOR YOUR HOUSEHOLD GOES OVER THE LIMIT BELOW

Number of People in your Household	Monthly	Weekly	Every 2 weeks	Twice a month
1	$1,037	$241.16	$ 482.32	$ 518.50
2	1,390	323.25	646.51	695.00
3	1,744	405.58	811.16	872.00
4	2,097	487.67	975.34	1,048.50
5	2,450	569.76	1,139.53	1,225.00
6	2,803	651.86	1,303.72	1,401.50
7	3,156	733.95	1,467.90	1,578.00
8	3,509	816.04	1,632.09	1,754.50
For each additional member add	+ $354	+ $82.32	+ $164.65	+ $177.00

These amounts are good through 9/30/06.

Add gross income for all the people in your household. New income total $ _____

THE NUMBER OF WORK HOURS IN A WEEK GOES UNDER 20 FOR MEMBERS WHO ARE 18-50 IF THERE ARE NO CHILDREN IN THE HOUSE

NAME	NUMBER OF HOURS	WHERE WORKING

IF YOU RECEIVE TANF, TELL US IF AN ELIGIBLE CHILD LEAVES YOUR HOME

Name	Date moved out	Name	Date moved out

CHANGES THAT MAY AFFECT VIEW PARTICIPATION FOR TANF. DISCUSS WITH YOUR VIEW WORKER.

Change that has occurred _____
_____

CHANGES YOU MAY WANT TO REPORT

CHANGE IN SHELTER EXPENSES

Rent or Mortgage $ per	Property Taxes $ per	Homeowner's Insurance $ per	Electricity $ per
Gas $ per	Oil $ per	Kerosene, Coal, wood, etc. List and give amount	
Water/Sewer $ per	Garbage $ per	Telephone (Basic Service Only) $ per	Installation Fees $ per

CHANGE IN DAY CARE EXPENSES

Person paying for care	Person receiving care	Amount billed $	How often?

CHANGE IN MEDICAL EXPENSES FOR MEMBER WHO ARE 60 OR MORE OR DISABLED

Name	Type of expense	Amount billed $

CHANGE IN LEGALLY OBLIGATED CHILD SUPPORT PAID TO ANOTHER HOUSEHOLD

Person paying support	Person receiving support	Amount legally obligated $ per	Amount paid $ per

CHANGE IN THE NUMBER OF PEOPLE IN YOUR HOUSEHOLD

Has ANYONE MOVED IN?

Name	Date moved in	Relationship to you		Social Security Number
Date of Birth		Race (not required)	Sex	Marital Status
U.S. Citizen Yes ( ) No ( )	If Alien, give alien number, date of entry	Last school grade completed		Currently in School? Yes ( ) No ( )

HAS ANYONE MOVED OUT?:

Name	Date moved out	Name	Date moved out

HOW LONG DO YOU EXPECT THE CHANGE(S) TO CONTINUE

( ) YES ( ) NO Do you expect any of the change(s) you listed on this report to continue beyond this month? If YES, explain

I declare that all information I gave on this form is correct and complete to the best of my knowledge and belief.

Signature_____ Date _____

CHANGE REPORT

FORM NUMBER - 032-03-051

PURPOSE OF FORM - To provide a recipient household with a method of reporting changes in circumstances.

USE OF FORM - Recipient households may use the form to report changes in circumstances. Households must report changes to the agency when they occur but no later than 10 days after the month of the change.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The agency must provide the Change Report to all households at the time of initial application and reapplication and at recertification if the income limits listed on the form have changed or if the household needs another form. The agency must also provide the Change Report form whenever the household returns a completed one **or reports a change in the household size**.

INSTRUCTIONS FOR PREPARATION OF FORM – The EW must complete information at the top of the form before providing the form to the household.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
FOOD STAMP PROGRAM

ENTITLEMENT TO RESTORATION OF LOST BENEFITS

CASE NUMBER	
DATE	
LOCALITY	WORKER

☐ YOU ARE ENTITLED TO A RESTORATION OF BENEFITS BECAUSE YOUR PRIOR ALLOTMENT WAS INCORRECTLY CALCULATED OR YOU WERE DENIED IMPROPERLY.

TOTAL AMOUNT OWED $_____ MONTH(S) RESTORATION COVERS_____

REASON_____

_____

☐ IF THIS BLOCK IS CHECKED, YOU WERE OVERISSUED FOOD STAMPS, YOUR RESTORATION WAS REDUCED BY THE AMOUNT YOU WERE OVERISSUED.

AMOUNT YOU WERE OVERISSUED $_____ AMOUNT YOU ARE ENTITLED TO RECEIVE$_____

☐ YOUR REQUEST FOR RESTORATION OF BENEFITS, DATED _____ WAS DENIED DUE TO

_____

_____

_____

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN REQUEST A FAIR HEARING. AT THE HEARING, YOU WILL HAVE A CHANCE TO EXPLAIN WHY YOU THINK WE MADE A MISTAKE. A HEARING OFFICER WILL DECIDE IF YOU ARE RIGHT. TO REQUEST A FAIR HEARING, OR IF YOU WANT TO KNOW MORE ABOUT HOW A FAIR HEARING WORKS.. CALL YOUR WORKER AT THE NUMBER SHOWN BELOW, OR CALL TOLL FREE 1-800-552-3431, OR WRITE TO:

HEARINGS AND LEGAL SERVICES MANAGER
VIRGINIA DEPARTMENT OF SOCIAL SERVICES
730 EAST BROAD STREET
RICHMOND, VIRGINIA 23219-1849

IF YOU WANT TO REQUEST A FAIR HEARING, YOU MUST DO SO WITHIN 90 DAYS FROM THE DATE OF THIS NOTICE.

FOR ADDITIONAL INFORMATION ABOUT APPEALS AND FAIR HEARINGS, PLEASE SEE THE BACK OF THIS NOTICE.

ELIGIBILITY WORKER	TELEPHONE NUMBER	FOR FREE LEGAL ADVICE CALL

032-03-153/10 (10/01)

CLIENT

APPEALS AND FAIR HEARINGS

A fair haring provides you opportunity to review the way a local social services agency has handled your situation concerning your stated need for food stamps. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services.

In addition to filing an appeal, you have the right to request a conference with your local social services agency, at which time the agency must give you an explanation of its proposed action. You must also be given the opportunity to present any information on which your disagreement with the agency's proposed action is based. At such a conference, you have the right to have your story presented by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receipt of your advance notice of proposed action to decrease or terminate your food stamps, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the local social services agency's action following the conference, and you want to request that your food stamps be continued as usual until a hearing decision is received, you must file an appeal within two days following the date of the conference. If you do not request a conference but file your appeal within 10 days of your advance notice of action to decrease or terminate your food stamps, your benefits may be continued until a hearing decision is reached. However, if the agency action is upheld, you will be required to repay assistance received during the appeal process.

If you request an appeal concerning food stamps, the local social service agency must offer you a conference after your appeal is filed.

If you wish to request a hearing, follow the instructions on the front of this form.

The person who conducts the hearing is someone from the State Department of Social Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call your service or eligibility worker immediately. If you need transportation, the local agency will provide it. You must bring a representative and/or witness to the hearing to help you tell your story. Your service or eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

(1) examine all documents and records which are used at the hearing;

(2) present your case or have it presented by a lawyer or by another authorized representative;

(3) bring witnesses;

(4) establish pertinent facts and advance arguments; and

(5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearings officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 60 days of the date your appeal request is received by the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency, consequently, if you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice you may contact your local legal aid office.

ENTITLEMENT TO RESTORATION OF LOST BENEFITS

FORM NUMBER - 032-03-153

PURPOSE OF FORM - To notify a household of its entitlement to restoration of lost benefits.

USE OF FORM - To be completed at the time the local agency determines a household is entitled to restoration of lost benefits, or denies a request for restoration.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The original is sent to the household. The copy is to be retained in the case record.

INSTRUCTIONS FOR PREPARATION OF FORM

Complete the identifying information at the top.

Check the first box to inform a household that it is entitled to a restoration. Complete the information requested on the form. If the restoration was offset against an amount which was previously overissued, check the small block in the second paragraph and complete the information requested.

Check the second box if the request for restoration is denied and complete the information requested.

Complete the information at the bottom of the form.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
FOOD STAMP PROGRAM

REQUEST FOR VERIFICATION/MISSED INTERVIEW

Case Name:_____

TO: _____ _____

Case Number:_____

Agency:_____

Date:_____

In order to determine your eligibility for food stamps or your continued eligibility for food stamps, you must provide the following information or take the following actions:

_____ Proof of your address
- ❑ Verification Form Attached

_____ Proof of who lives in your household and relationship

_____ Proof of your household's income
- ❑ Verification Form Attached

_____ Other_____

_____

_____

_____

_____

_____

_____

Please take the requested action by _____ or we will close your food stamp case or deny your application.

_____ You missed the interview to discuss your food stamp application on _____.
You must reschedule the interview or we will deny your application.

_____ _____
Eligibility Worker Telephone number

Reminder: Be sure to report changes in your circumstances to the agency within 10 days.

032-03-385/1 (6/03)

Request for Verification/**Missed Interview**

FORM NUMBER - 032-03-385

PURPOSE OF FORM - To request a household provide clarification or verification of the household's circumstances or to notify the household of a missed scheduled interview.

USE OF FORM - The Eligibility Worker (EW) must complete the form to request clarification, verification, or action taken by an applying or participating household. The household must take the requested action within ten days. The EW must follow this form with an Advance Notice of Proposed Action or Notice of Action if the agency alters the household's eligibility or benefit level in response to the Request for Verification form.

This form is not intended to amend the request for information or verification needed for an application. The EW should send a revised Checklist of Needed Verifications in this instance.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The agency must mail the form to the household and retain a copy of the completed form.

INSTRUCTIONS FOR PREPARATION OF FORM - The worker must complete the general case information and note the specific request for which the household is responsible for completing, including rescheduling an interview. The worker must also include the deadline for the submission of the information that is ten days after the mailing date. **The EW does not need to include a date at the bottom of the form if the household fails to attend a scheduled interview if this is the sole purpose for sending the household the notice.**

Commonwealth of Virginia
Department of Social Services
REQUEST FOR ASSISTANCE
--- ADAPT ---

GENERAL INFORMATION

This Request for Assistance is the first part of the application process and protects your application date. You must also complete the second part of the application process by (1) having an interview, or (2) completing an Application for Benefits form, or another appropriate Medicaid application.

With this Request for Assistance, you can begin the application process for one or more of the following assistance programs. You can also use this Request to request a Medicaid resource assessment for long term care.

- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- Medicaid Children's Health Insurance
- General Relief
- Emergency Assistance
- State and Local Hospitalization
- Refugee Cash Assistance
- Refugee Medical Assistance

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required, but if you decide not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help some else receive benefits, you could be arrested and prosecuted for fraud. You must also provide required verifications.

SPECIAL INFORMATION FOR FOOD STAMP APPLICANTS

You can begin the application process for Food Stamps by completing this Request for Assistance or by completing only the information in the boxes below and providing at least your **name, address, and signature.** You must complete the rest of the application process before your eligibility can be determined.

You must also be interviewed. Under certain hardships, you can be interviewed by telephone. You may turn in this Request for Assistance before you are interviewed. This is important because if you are eligible for the month in which you apply, your food stamp amount will be based on the date you actually turn in your Request.

EXPEDITED SERVICE FOR FOOD STAMPS

Your household may qualify for Expedited Service and receive food stamps within 7 days if you are eligible and your gross monthly income is less than $150 and liquid resources are $100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farmworker household with little or no income and resources. **GIVE THE INFORMATION REQUESTED IN THE BOXES BELOW, SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions	$_____
Total cash, money in checking/savings accounts, CDs	$_____
Total rent or mortgage for this month	$_____
Total utility expenses for this month	$_____
Do no count amounts due for previous months. Count only the basic telephone service cost.	
Is anyone in your household a migrant or seasonal farmworker	YES ( ) NO ( )

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

VERIFICATION AND USE OF INFORMATION

The information that you give may be matched against Federal, State, and local records including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it incorrect, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social service agency at the same time, and make required program changes.

The INCOME AND ELIGIBLITY VERIFICATION SYSTEM (IEVS) will also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of social security and Supplemental Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the U.S. Citizenship and Immigration Services (USCIS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

VIRGINIA SOCIAL SERVICES – BENEFIT PROGRAMS BOOKLET

This booklet contains information about the programs available at your local social services agency plus other very important information you should know, including your responsibilities. READ THIS BOOKLET CAREFULLY. Refer to the APPEALS Section if you have a complaint about an action taken on your case.

COMPLETING THE REQUEST FOR ASSISTANCE

If you need help completing this Request for Assistance, a friend or relative or your eligibility worker can help you. If you are completing this Request for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 6 people are living in your home and you need more space to list everyone, tell the agency you need extra pages.

FILING A REQUEST FOR ASSISTANCE

You may turn in a partially completed Request for Assistance which contains at least your **name, address, and signature** (or the signature of your authorized representative), but you must complete the rest of the application process before your eligibility can be determined. For some programs, you must also be interviewed, but you may turn in your Request for Assistance before your interview.

You may return your Request for Assistance by mail, fax, or in person. If you return the form in person, you may turn it in any time during office hours the same day you contact your local social services agency. You have the right to file your Request for Assistance, even it looks like you may not be eligible for benefits.

Your Food Stamps Rights

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs and disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD), USDA is an equal opportunity provider and employer.

AGENCY USE ONLY
EXPEDITED SERVICE DETERMINATION

Income less than $150 and Resources $100 or less — **YES ( ) NO ( )**

Income plus resources less than shelter bills — **YES ( ) NO ( )**

For migrants or seasonal farmworkers:

Resources $100 or less, and in next 10 days $25 or less is expected from new income:

OR

Resources $100 or less, and no income is expected from a terminated source for the rest of this month or next month. — **YES ( ) NO ( )**

EXPEDITE IF YES TO ANY OF THE ABOVE

Commonwealth of Virginia
Department of Social Services
REQUEST FOR ASSISTANCE
--- ADAPT ---

AGENCY USE ONLY			
CASE NAME	CASE NUMBER(S)	PROGRAM(S)	REGISTRATION NUMBER
APPLICATION TYPE	LOCALITY	WORKER	CASELOAD NUMBER
DATE OF SERVICE REFERRAL		DATE RECEIVED	

1.

APPLICANT'S NAME	C/O NAME	PHONE NUMBER (HOME/MESSAGES) (WORK)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP)	MAILING ADDRESS (IF DIFFERENT)	DIRECTIONS TO HOME

2. Check ( ) your household's primary language: ( ) English ( ) Spanish ( ) Cambodian ( ) Vietnamese ( ) Other_____
( ) Kurdish ( ) Arabic ( ) Japanese ( ) German ( ) French ( ) Farsi
( ) Somali ( ) Haitian-Creole ( ) Laotian ( ) Chinese ( ) Korean

3. LIST EVERYONE LIVING IN YOUR HOME, even if you are not requesting assistance for that person. List yourself on the first line. If you are married, list your spouse on the second line. Then list everyone else. Provide the information requested for each person listed. Check (□) type of assistance requested for each person. If no assistance is requested, check NONE for that person. A Social Security Number and an Alien Registration Number do not have to be provided for any individual for whom assistance is not being requested.

NAME FIRST MI LAST SUFFIX (JR., SR.)	SEX M,F	RACE SEE* BELOW	ETHNICITY SEE** BELOW	DATE OF BIRTH	SOCIAL SECURITY NUMBER	ALIEN REGISTRATION NUMBER	Food Stamp	TANF	MEDICAID CHILDREN'S HEALTH INSURANCE	GENERAL RELIEF	EMERGENCY ASSISTANCE	STATE & LOCAL HOSPITALIZATION	REFUGEE MEDICAL ASSISTANCE	REFUGEE CASH ASSITANCE	MEDICAID RESOURCE ASSESSMENT	NONE	THIS PERSON'S RELATIONSHIP TO YOU	AGENCY USE ONLY CLIENT ID
(Your Name)																		
(Your Spouse's Name, if you are married)																		

* RACE: (Not required) Use these codes to indicate RACE: 1 – White, 2 – Black or African American, 3 – American Indian or Alaska Native, 4 – Asian, 5 – Native Hawaiian or Pacific Islander. 6 – American Indian or Alaska Native and White, 7 – Asian and White, 8 – Black or African American and White, 9 – American Indian or Alaska Native and Black or African American, A – Asian and Black, B - Other

** ETHNICITY: (Not required) Use these codes to indicate ETHNICITY: 1 – Hispanic or Latino, 2 – Not Hispanic or Latino

4. List anyone from #3 above who is pregnant_____
or who is disabled:_____

5. List anyone from #3 above who is requesting Medicaid who had medical treatment during the 3 months before this request:_____

6. YES ( ) NO ( ) Have you or anyone for whom you are applying ever applied for or received or are currently receiving any benefits from a social services agency, including Food Stamps, AFDC, TANF, Medicaid Children's Health Insurance, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, Refugee Cash or Medical Assistance?

Person Who Applied for or Received Benefits	Under What Case Name	Type of Benefits Received
When	From What County or City of State	

7. YES ( ) NO ( ) Does anyone have any of the following emergencies? If **YES,** check (✓) the type of emergency and explain the cause.
( ) Food ( ) Shelter ( ) Medical ( ) Clothing ( ) Other Emergency_____
Cause: _____

8. YES ( ) NO ( ) Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, child care needs, family planning, family violence, referrals to other community organizations, or other problems or concerns. If **YES**, explain.

Explain:

BY MY SIGNATURE BELOW I DECLARE, UNDER PENALTY OF PERJURY, THAT ALL OF THE FOLLOWING ARE TRUE:
I understand:

- All of the information in the GENERAL INFORMATION Section on pages 1 and 2.
- If I give false, incorrect, or incomplete information, I may be breaking the law and could be prosecuted for perjury, larceny, or welfare fraud.
- If I helped someone else complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.

I received the Benefit Programs Booklet **YES ( ) NO ( )** **MEDICAID APPLICANTS:** I received the Virginia Medicaid Handbook **YES ( ) NO ( )**

All information I gave on this Request for Assistance is correct and complete to the best of my knowledge and belief. I authorize the release to this agency of all information necessary to determine my eligibility.

I filled in this Request for Assistance myself. **YES ( ) NO ( )** If **NO**, it was read back to me when completed. **YES ( ) NO ( )**

APPLICANT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	WITNESS TO MARK OR INTERPRETER	DATE

COMPLETE THE BOX BELOW IF THIS REQUEST FOR ASSISTANCE WAS COMPLETED FOR THE APPLICANT BY SOMEONE ELSE:

APPLICANT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	ADDRESS
PHONE NUMBER (HOME) (WORK)		RELATIONSHIP TO APPLICANT

REQUEST FOR ASSISTANCE

FORM NUMBER - 032-03-875

PURPOSE OF FORM - To indicate intent to apply for benefits by applicant.

USE OF FORM - To be completed by an applicant to begin the application process through the ADAPT system. The form completed with the applicant's name, address and signature will secure the application date regardless of the eventual date of completion of the interactive interview and signed Statement of Facts. The form will also allow an evaluation of entitlement to expedited service processing.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The form must be retained in the case record with the appropriate Statement of Facts.

INSTRUCTIONS FOR PREPARATION OF FORM - General instructions appear of the form for completion.

If changes need to be made after the application is completed, the applicant should write the revised information near the original entry. The applicant must initial and date the changes. Except for agency-use sections, eligibility workers may not add to or write on a completed application.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

INTERIM REPORT FORM - REQUEST FOR ACTION

Case Name:_____

Case Number:_____

Agency:_____

Date:_____

You were required to send in a completed Interim Report to this agency by the fifth (5th) of the month for your TANF and/or your food stamp case. Please note the information checked below.

( ) We have not received an Interim Report form from you. A copy of the Interim Report is attached. When you send it in, please make sure you answer every question, attach all the information the report asks for, and sign and date the report.

( ) The Interim Report form you submitted was incomplete. The form you submitted is attached. This form is incomplete because:

1. ( ) You did not answer every question. Please answer the following questions: _____

_____

2. ( ) Proof of some of the statements made on your report was missing, and without the proof we are requesting, the amount of food stamps or TANF you receive may be decreased or your case will be closed. Please send in the following proof: _____

_____

_____

3. ( ) You did not sign and/or date the report. Please sign and date the report.

You must return a completed Interim Report and proof of any changes within ten (10) days, by _____. If you do not submit a completed report by this date, your Food Stamp or TANF case will close. **You will not receive an additional notice** unless the information you submit changes your benefits.

If you are unable to complete the Interim Report or if you have any questions about how to complete it or what information you need to send in, you may ask your local agency worker for help.

Worker	Telephone Number	For Free Legal Advice Call

032-03-649/1 (7/04)

APPEALS AND FAIR HEARINGS

If you do not agree with the action we are proposing or the amount of benefits you are receiving, you may have a fair hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake and a hearing officer will decide if you are right. A hearing gives you a chance to review the way a local social services agency handled your situation about your need for TANF or food stamps. The hearing is a private, informal meeting at the local social services agency with you and anyone you want to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearings officer. The hearing officer is the official representative of the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you want free legal advice, you may contact your local legal aid office.

How to File an Appeal

- Send a written request to the **Virginia Department of Social Services, Attention: Hearing and Legal Services Manager, 7 North Eighth Street, Richmond, Virginia 23219-3301**
- Call me at the number listed on the front
- Call **1-800-552-3431**

When to Appeal

- Within the next 30 days for TANF and within the next 90 days for food stamps.
- Within 10 days of the date on this form to get the food stamps continued.*
- Before the effective date of the change to get the TANF benefits continued.*

*Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

Local Agency Conference

In addition to filing an appeal, you may have a conference with your local social services agency. During the conference, the agency must explain its proposed action. You will have the chance to present any information where you disagree with the agency's proposed action. You may present your story by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receiving of your notice to decrease or end your TANF or food stamps benefits, the proposed action will not take place until after there is a decision made for the conference.

If the conference does not satisfy you and you want to continue to receive your benefits until there is a hearing decision, you must file an appeal for TANF benefits within two days following the date of the conference and within 10 days of the conference date for food stamps. If you do not ask for a conference but you file an appeal within 10 days of the notice of action to reduce, suspend, or terminate your TANF or food stamps, you may continue to receive benefits until there is a hearing decision. If you appeal the proposed action on your TANF case before the reduction, suspension or termination effective date, you may also receive continued coverage. Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

Hearing Process and Decision

The hearing officer will notify you of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your eligibility worker immediately. If you need transportation, the local agency will provide it.

At the hearing, you and/or your representative will have the opportunity to:

- Examine all documents and records used at the hearing;
- Present your case or have it presented by a lawyer or by another authorized representative;
- Bring witnesses;
- Establish pertinent facts and advance arguments; and
- Question or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

The hearings officer will base the decision only on the evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In this event, you and the local social services agency would have the opportunity to question or refute this additional information.

You will get the hearings officer's decision in writing on your appeal within 60 days of the date the State Department of Social Services receives your appeal request.

INTERIM REPORT FORM – REQUEST FOR ACTION

FORM NUMBER – 032-03-649

PURPOSE OF FORM – To notify a household of required actions it must take for submitting the Interim Report or any needed verifications.

USE OF FORM – The agency may use this form to tell households what action is needed to process the Interim Report to avoid closure of the case.

NUMBER OF COPIES – Two

DISPOSITION OF FORM – The agency must notify households when they fail to complete the Interim Report form or fail to submit needed verification or information. If the household fails to submit the Interim Report, the EW must include another copy of the Interim Report with this request for action. If the household files an incomplete form or fails to submit needed information, the EW must return the original Interim Report to the household along with this action form.

INSTRUCTIONS FOR PREPARATION OF FORM – The EW must complete identifying case and agency information at the top of the form. The EW must complete the action required of the household and include a date for submitting the form or information/verification. The EW must sign and date the form and include a telephone number for legal assistance.

Commonwealth of Virginia
Department of Social Services

PERMANENT VERIFICATION LOG

Case Name	Case Number	FIPS	EW	Date
Secondary Case Name	Secondary Case Number			

DOCUMENT METHODS AND DATES OF VERIFICATION REQUIRED BY PROGRAM(S) BEING EVALUATED.

1. MEMBER INFORMATION

	MBR #	NAME LAST FIRST MI	SOCIAL SECURITY NUMBER (# of APP mm/dd/yy)	DATE OF BIRTH	CITIZENSHIP/ ALIEN STATUS	RELATIONSHIP
1			VFN:	VFN:	VFN:	VFN:
2			VFN:	VFN:	VFN:	VFN:
3			VFN:	VFN:	VFN:	VFN:
4			VFN:	VFN:	VFN:	VFN:
5			VFN:	VFN:	VFN:	VFN:
6			VFN:	VFN:	VFN:	VFN:
7			VFN:	VFN:	VFN:	VFN:
8			VFN:	VFN:	VFN:	VFN:

INDICATE ANY CHANGES TO THE ABOVE INFORMATION AND DOCUMENT METHOD AND DATE OF VERIFICATION.

2. DOCUMENTS AND VERIFICATIONS (WHEN REQUIRED BY POLICY)

BIRTH RECORDS AND IMMUNIZATIONS

Name	Dob	Place Of Birth	Sex	Race
Mother's Maiden Name	Father's Name	BVS#/VFN		
Immunizations, Dates				

Name	DOB	Place Of Birth	Sex	Race
Mother's Maiden Name	Father's Name	BVS#/VFN		
Immunizations, Dates				

Name	DOB	Place Of Birth	Sex	Race
Mother's Maiden Name	Father's Name	BVS#/VFN		
Immunizations, Dates				

Name	DOB	Place Of Birth	Sex	Race
Mother's Maiden Name	Father's Name	BVS#/VFN		
Immunizations, Dates				

MARRIAGE RECORDS

Wife's Maiden Name		Husband's Name
Date of Marriage	Place	VFN

DIVORCE RECORDS

Husband		Wife
Date of Divorce	Place	VFN

DEATH RECORDS

Name of Deceased		
Date of Death	Place	VFN

PERMANENT VERIFICATION LOG

FORM NUMBER - 032-03-823A

PURPOSE OF FORM - To document verification of eligibility factors which are generally not subject to change.

USE OF FORM - To be completed, at initial certification, recertification or during the certification period, when a household has a circumstance requiring a one-time-only verification or a change requiring verification.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The form is to be kept in the case record. If additional space is needed, use an additional form.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form.

Complete the elements required for the Food Stamp Program. If an element does not apply, leave the element blank. Document the method and date of verification for each element required.

Document changes to previously verified information and document the method and date of verification for the change.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF BENEFIT PROGRAMS

NON-RECEIPT AFFIDAVIT/EBT CARD REPLACEMENT REQUEST

CASE NUMBER		
FS CASE NAME	DATE	LOCALITY
ADDRESS	CITY, STATE, ZIP	

CHECK (✓) THE BOX BELOW WHICH DESCRIPBES THE REPLACEMENT REASON:	How was the EBT card of food destroyed or damaged?
❑ Non receipt of authorization to participate (EBT) card ❑ Food destroyed in a household disaster ❑ EBT card destroyed/stolen	
Value of destroyed food	If the EBT card was stolen, have you filed a police report? ❑ Yes ❑ No Where filed?_____ Date:_____

I hereby certify, under penalty of perjury and/or fraud, that the household listed above has not received its electronic benefits transfer (EBT) card or has experienced the destruction of food, the destruction of the EBT card, or has experienced the theft of an EBT card in the month of _____, (year)

_____

Signature	Date

The Virginia Department of Social Services is an equal opportunity provider.

032-03-388 (10/01)

CLIENT

NON-RECEIPT AFFIDAVIT/EBT Card Replacement Request

FORM NUMBER - 032-03-388

PURPOSE AND USE OF FORM – This form will allow the local agency to assess the reason for a replacement of an EBT card or determine the value of food destroyed. Depending on the reason for the loss, the local agency may credit the card replacement fee back to the household's EBT account or provide additional food stamp benefits to cover the value of food destroyed.

USE OF FORM – The local agency must provide the affidavit to households that request the form or who request a credit of the card replacement fee. The agency must provide the form to households that report the loss or destruction of the EBT card due to a reason for which the local agency may credit the card replacement fee. The agency must also provide the form to households that report a household disaster that resulted in the loss of food purchased with food stamp benefits.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM – The local agency must provide a copy of the completed form to the household and file a copy in the case record.

INSTRUCTIONS FOR PREPARATION OF FORM - Local agency staff should complete the identifying case information at the top of the form. A household member or an authorized representative must complete or provide information for the bottom section regarding the replacement of the EBT card or food destroyed. A household member must sign and date the form.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF BENEFIT PROGRAMS

INTERNAL ACTION AND VAULT EBT CARD AUTHORIZATION

TO: _____ Vault Card Issuance Unit _____ EBT Administrative Terminal Personnel Date ____/____/____

FROM Eligibility Worker/Supervisor: _____ Telephone Number:_____

RE: Case Name:_____ Case Number:_____

I. [ ] Authorization for a Vault EBT Card
Vault card reason: (1) ___ Timely processing (2) ___ Household emergency (3) ___ Agency determination

Case Name Social Security Number_____ Case Name Birth Date ____/____/____

[ ] Issue a vault card to Authorized Representative _____

Address of vault card recipient: _____

II. [ ] Authorization for crediting the card replacement fee to the household's account

Reason: ❑ Household disaster: ❑ Lost in the mail ❑ Household Violence
❑ Improperly manufactured ❑ Reapplication, no card ❑ Cardholder name changed

III. [ ] Administrative error – Debit account for $_____

IV. [ ] Reactivate dormant EBT account.

V. [ ] Repay FS Claim of $_____ from ❑ Active ❑ Dormant/expunged account

---

Issuance/Administrative Unit Use

I. EBT Vault Card Number:_____ Card destroyed on _____/_____/_____

Type of identification seen:
❑ Driver's License ❑ Rent/Utility Bill/Receipt ❑ School ID Card ❑ Work ID Card
❑ Library Card ❑ Social Security Card ❑ Other _____

I acknowledge that I received my EBT card or that I received the card on behalf of another household. I understand that I need to select a Personal Identification Number to use my benefits.

_____ _____
Cardholder's Signature Date

[ ] Cardholder failed to pick up vault card. ❑ Card destroyed ❑ Vault card not prepared

II. Replacement fee credited on _____/_____/_____.

III. EBT account debited for $_____ for an administrative error on _____/_____/_____.

IV. EBT account reactivated on _____/_____/_____.

V. Repaid $_____ to FS Claim on _____/_____/_____.

Completed by _____ _____
Issuance/Administrative Worker Date

032-03-387/4 (4/05)

Internal Action and Vault EBT Card Authorization

FORM NUMBER - 032-03-387

PURPOSE OF FORM - The Eligibility Unit will use this form to communicate with the Issuance or Administrative Unit in the local agency.

USE OF FORM - The EW must complete the top portion of the form to authorize the Issuance Unit to prepare and issue a vault card to an eligible household **or authorized representative**. The Eligibility Supervisor must complete the top portion of the form to authorize the Issuance or Administrative Supervisor, as designated by the agency, to credit the card replacement fee to a household's EBT account. The Issuance or Administrative Unit must complete the bottom portion of the form to document the action taken. The primary cardholder **or authorized representative** must also sign the form to acknowledge receipt of the vault card. The agency must use the internal action form to document repayment of a claim with funds in an EBT account or to debit an account for an administrative error.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The Eligibility Worker or Supervisor must retain a copy of the form and forward the remaining copies to the Issuance or Administrative Unit for completion. The Issuance or Administrative Unit must retain a copy of the fully completed form and return the second copy to the Eligibility Unit. Upon receipt of the form, the Eligibility Worker or Supervisor must file the copy in the case file. The initial copy completed only by the Eligibility Unit may be discarded.

INSTRUCTIONS FOR PREPARATION OF FORM - The EW or Supervisor must complete the identifying case and unit information. The EW or Supervisor must complete the appropriate section of the top portion of the form to explain or authorize actions, including Section I to note why a vault card is necessary. **The EW must include the address of the person who will receive the vault card, either the primary cardholder or authorized representative, for entry in the EBT system. The EW may attach a copy of the AECASE or AECAS1 ADAPT screen, as appropriate, to avoid transcription errors.**

The Eligibility Supervisor must complete Section II to authorize crediting the card replacement fee back to the household's EBT account. The Eligibility Supervisor must also complete Section III to debit benefits from an account that were erroneously deposited as a result of an administrative error.

The EW or Supervisor may authorize the reactivation of a dormant account by completing Section IV. The Primary Cardholder may also contact the Issuance or Administrative Worker directly to request the reactivation of the account. The EW or supervisor may also authorize deducting funds from an account to repay a claim by completing Section V.

The Issuance Unit must promptly act to prepare a vault card for a household upon receipt of the form completed by the Eligibility Unit. The Issuance Worker must obtain and record identity verification before releasing the vault card and secure the signature of the **primary** cardholder **or authorized representative** on the form.

The completed form must remain with a prepared vault card until the cardholder comes to the agency. The Issuance Unit must destroy the card after five business days if the cardholder does not receive it or make additional arrangements to receive the card. The Issuance Worker must note the date of the destruction of the card on the form. If the agency opts to wait until the cardholder comes to pick up the vault card before preparing the card, the Issuance Unit must notify the EW if the cardholder fails to obtain the card within five business days after the initial authorization by the certification unit.

The supervisor of the Issuance or Administrative Unit, as determined by the agency, must complete the section to credit the card replacement fee back to the household's EBT account.

The Issuance or Administrative Worker or Supervisor must sign and date the form.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

Locality;_____
Case No.:_____
Category: ❑ GR ❑ FS ❑ Other (Specify)_____

EMPLOYMENT SERVICES REGISTRATION FORM

SECTION I IDENTIFYING INFORMATIN (this section is completed by the eligibility worker.)

REGISTRANTS NAME: _____
FIRST MIDDLE LAST

CASE NAME:_____
FIRST MIDDLE LAST

DATE OF BIRTH:_____SSN:_____

ADDRESS:_____

MAILING ADDRESS:_____

TELEPHONE NUMBER: _____

SECTION II REGISTRATION (This section is completed by the person registering for Employment Services.)

- MANDATORY REGISTRANT: I have read the reverse of this form, have received the booklet explaining the program and have had the program explained to me. I understand that registration for the Employment Services Program is necessary in order to be eligible for assistance. I further understand that I or the person required to register may have to:

  (a) seek jobs on my (their) own and in cooperation with the Employment Services staff:

  (b) respond to agency requests; and

  (c) participate in employment and training activities to which I am (they are) assigned.

  SIGNATURE: _____ DATE:_____

- VOLUNTARY REGISTRANT: I understand that I am registering voluntarily for Employment Services and that I may withdraw at any time without any effect on my allotment. I understand that if I become a mandatory registrant, I must meet Employment Services requirements.

SECTION III – COMMENTS (This section is completed by the eligibility worker.)

Food Stamp Application approval date _____Certification period from _____to _____

Are benefits time limited or would they be time limited if the individual did not reside in a waived locality? Yes ( ) No ( )

Does registrant read and write English? Yes ( ) No ( ) Unknown ( )

Is registrant working part-time? Yes ( ) No ( ) Unknown ( )

Is registrant potentially eligible for unemployment benefits? Yes ( ) No ( ) Unknown ( )

EMPLOYMENT SERVICE UNIT
Date Referral Received

Eligibility Worker Signature _____

Worker Number _____Date _____

032-03-071/9 (7/99

ELIGIBILITY UNIT

RIGHTS AND RESPONSIBILITIES FOR MANDATORY REGISTRANTS

Registration for and participation in the Employment Services Program is a condition of your eligibility to receive assistance.

This means that:

APPLICANTS FOR FOOD STAMPS

If you are applying for Food Stamps and you fail to register for Employment Services, you will be denied benefits for yourself. Your household may also be ineligible until registration occurs.

RECIPIENTS

GENERAL RELIEF — If you are a recipient of General Relief and you fail, without good cause to participate, you will not be eligible for assistance.

FOOD STAMPS — If you are a recipient of Food Stamps and you fail, without good cause, to participate, you or your entire household will be sanctioned (disqualified) from Food Stamps for:

--one month, or until you comply, whichever is longer, for a first sanction,
--three months, or until you comply, whichever is longer, for a second sanction,
--six months, or until you comply, whichever is longer, for a third and any subsequent sanctions.

If you need help with child care or transportation in order to participate, you will receive such help or you will be excused from participating.

If your assistance is denied or reduced as a result of a determination that (1) you have not registered: or (2) you have failed, without good cause, to participate, you may request a hearing to determine if the agency acted properly. Good cause will exist if you are unable to participate in the program due to an event or change in circumstances outside of your control.

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs.

IF YOU HAVE ANY QUESTIONS ABOUT REGISTRATION, CONTACT YOUR ELIGIBILITY WORKER.

IF YOU HAVE ANY OTHER QUESTIONS ABOUT THE REQUIREMENTS OF THE EMPLOYMENT SERVICES PROGRAM, CONTACT YOUR EMPLOYMENT SERVICES WORKER.

EMPLOYMENT SERVICES REGISTRATION/REPORTING FORM

FORM NUMBER - 032-03-071

PURPOSE OF FORM - To be completed in order to meet the work registration requirements in Part VIII.A.

USE OF FORM - To be used in agencies which run an Employment and Training Program for food stamp recipients. The pamphlet, "FSET - Making the Right Moves", must be given to each registrant at the time of the registration.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is to be kept in the eligibility case record. The first copy is to be forwarded to the Employment Services Unit in the local agency within five days of certifying the household. The second copy is to be given to the applicant when the form is signed.

INSTRUCTIONS FOR PREPARATION OF FORM - The EW must complete the identifying information at the top of the form, Section I and Section III.

The information on the back of the form and before the signature line in Section II must be reviewed with the applicant at the time the form is signed. Only persons required to be registered will be referred so, the applicant must sign and date the form in the Mandatory Registrant section.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
EMPLOYMENT SERVICES PROGRAMS
COMMUNICATION FORM

REGISTRANT _____
CASE NAME _____
CASE NUMBER _____
❑ **FSET** ❑ **GR** ❑ **TANF** ❑ **TANF-UP**

TO _____, **EW**
FROM _____, **ESW**

Date _____
Reply Needed By _____

❑ Reevaluation of non-exempt/mandatory status is requested because _____

❑ Volunteer no longer wishes to participate.

❑ Individual will enter/entered employment on __/__/__
#Hours/week _____ Rate of pay $_____ Per _____
Employer _____

❑ Please send verification of employment.

❑ Individual will enter education or training activity on __/__/__
Location _____

❑ Individual will be a participant in work experience. Please provide the FS or GR dollar amount for the month of _____

❑ Individual has failed to comply with program requirements.
Reason _____

❑ Good cause does not exist.

❑ Notify ESW if aware of good cause reason.

❑ Comparability exists.

❑ Sanction for (check appropriate answer):
_ until notified of compliance _ 3 months and compliance
_ 1 month and compliance _ 6 months and compliance

❑ Please provide the dollar amount of reduction due to employment or sanction.

❑ Please notify when sanctioned individual has been added back to FS unit.

❑ Other _____

TO _____, **ESW**
FROM _____, **EW**

Date _____
Reply Needed By _____

❑ Result of reevaluation of non-exempt/mandatory status _____

❑ Non-exempt/mandatory individual now exempt.
Reason _____

❑ Volunteer no longer wishes to participate.

❑ Individual will enter/entered employment on __/__/__
#Hours/week _____ Rate of pay $_____ Per _____
Employer _____

❑ Individual/household no longer eligible for FS or GR. Case closed due to: (check one)
❑ Sanction-ANPA sent
❑ Employment-Benefit reduction/savings information provided below
❑ Other _____
Effective Date _____

❑ Individual deleted from FS household due to: (check one)
❑ Sanction, ANPA sent
❑ Other _____
Effective Date _____

❑ Effective with payment on __/__/__, benefits will be reduced from $_____ to $_____

❑ Individual appealed sanction. Pre-hearing conference scheduled for __/__/__ at _____(time).

❑ Sanction ended effective __/__/__
Mandatory registrant has been added back to FS unit.

❑ Amount of FS allotment/GR payment for month of _____ was $_____

❑ Individual may be unable to participate in ESP/FSET program because _____

❑ New certification period:
from _____ to _____

❑ Individual can: ❑ Read English ❑ Write English

❑ Other _____

EMPLOYMENT SERVICES PROGRAMS COMMUNICATIONS FORM

FORM NUMBER - 032-02-072

PURPOSE OF FORM - To exchange information about ESP clients between the eligibility worker and the Employment Services worker.

USE OF FORM - To be originated by either the eligibility worker or the Employment Services worker at the time circumstances change, for the registrant, that require the exchange of information.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - This form is prepared in triplicate. Distribution of the top two copies is indicated on the form. The third copy remains attached to the copy being forwarded, in the event the receiving party uses the same form for reply.

INSTRUCTIONS FOR PREPARATION OF FORM

The name of the registrant, the case name, case number and program are to be entered in the upper right hand corner by the worker who originates the form.

The top half of the form is completed when messages must be communicated to eligibility staff from employment services staff. The employment services worker will check whichever block communicates the desired information or requests the desired information.

The bottom half of the form is completed when the eligibility staff is either returning the form to employment services with the requested information completed, or when the eligibility staff is communicating information to employment services. The eligibility worker will check whichever blocks are applicable to the situation.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
FOOD STAMP PROGRAM

FOOD STAMP SANCTION NOTICE FOR NON-COMPLIANCE WITH A WORK REQUIREMENT

CASE NUMBER	
LOCALITY	
WORKER	DATE

NAME:_____

- VOLUNTARILY AND WITHOUT GOOD CAUSE QUIT A JOB.
- VOLUNTARILY AND WITHOUT GOOD CAUSE REDUCED THE HOURS WORKED TO LESS THAN 30 HOURS PER WEEK.
- REFUSED OR FAILED TO COMPLY WITH THE FOLLOWING EMPLOYMENT PROGRAM REQUIREMENT:
  _____

AS A RESULT, THE FOLLOWING SANCTION WILL BE APPLIED IN YOUR FOOD STAMP CASE.

- THE PERSON NAMED ABOVE IS DISQUALIFIED AND WILL NOT BE ELIGIBLE TO RECEIVE FOOD STAMP BENEFITS FOR THE MONTHS OF _____. HOWEVER, IF THE PERSON REFUSED OR FAILED TO COMPLY WITH AN EMPLOYMENT PROGRAM REQUIREMENT, THE PERSON MUST COMPLY WITH THAT REQUIREMENT IN ORDER TO RECEIVE FOOD STAMPB ENEFITS.

- YOUR HOUSEHOLD'S FOOD STAMP ALLOTMENT OF $_____WILL BE CHANGED TO $_____ EFFECTIVE _____.

- YOUR ENTIRE HOUSEHOLD WILL NOT BE ELIGIBLE TO RECEIVE FOOD STAMP BENEFITS FOR THE MONTHS OF _____. HOWEVER, IF THE PERSON NAMED ABOVE REFUSED OR FAILED TO COMPLY WITH AN EMPLOYMENT PROGRAM REQUIREMENT, THE PERSON MUST COMPLY WITH THAT REQUIREMENT IN ORDER FOR YOUR HOUSEHOLD TO RECEIVE FOOD STAMP BENEFITS.

THE SANCTION INDICATED ABOVE CAN BE LIFTED BEFORE THE END OF THE SANCTION PERIOD IF YOUR HOUSEHOLD IS OTHERWISE ELIGIBLE AND THE PESON NAMED ABOVE LEAVES THE HOUSEHOLD OR BECOMES EXEMPT FROM THE REQUIREMENT TO REGISTER FOR WORK.

IF YOU DO NOT AGREE WITH THE PROPOSED ACTION, YOU MAY WRITE OR CALL YOUR WORKER, WHOSE NAME, ADDRESS AND PHONE NUMBER APPEAR BELOW, AND ASK FOR A CONFERENCE OR, YOU CAN HAVE A FAIR HEARING ON YOUR CASE. AT THE HEARING YOU WILL HAVE A CHANCE TO EXPLAIN WHY YOU THINK WE MADE A MISTAKE, AND AHEARING OFFICER WILL DECIDE IF YOU ARE RIGHT. TO REQUEST A FAIR HEARING, JUST CALL OR WRITE YOUR WORKER, OR WRITE **TO THE VIRGINIA DEPARTMENT OF SOCIAL SERVICES, 730 EAST BROAD STREET, RICHMOND, VIRGINIA 23219-1849, ATTENTION: HEARING AND LEGAL SERVICES MANAGER.** PLEASE SEE THE BACK OF THIS FORM FOR AN EXPLANATION OF HEARINGS.

YOU CAN ALSO REQUST A FAIR HEARING BY CALLING TOLL FREE 1-800-552-3431. YOU MUST REQUEST YOUR FAIR HEARING WITHIN 90 DAYS. IF YOU APPEAL THE ACTION ON YOUR CASE BEFORE _____ ASSISTANCE MAY CONTINUE. HOWEVER, IF ASSISTANCE IS CONTINUED. YOU MAY HAVE TO REPAY BENEFITS YOU RECEIVED DURING THE APPEAL PROCESS IF THE HEARING DECISION SUPPORTS THE AGENCY ACTION.

Eligibility Worker:	Agency Address	Agency Phone
For Free Legal Advice Call:	This Number is a Local Legal Services Agency	

032-03-174/5 (11/01) (Combines former versions of 032-03-174 and 032-03-175)

APPEALS AND FAIR HEARINGS

A fair haring provides you opportunity to review the way a local social services agency has handled your situation concerning your stated need for food stamps. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer.

In addition to filing an appeal, you have the right to request a conference with your local social services agency, at which time the agency must give you an explanation of its proposed action. You must also be given the opportunity to present any information on which your disagreement with the agency's proposed action is based. At this conference, you have the right to have your story presented by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receipt of your advance notice of proposed action to decrease or terminate your food stamps, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the local social services agency's action following the conference, and you want to request that your food stamps be continued as usual until a hearing decisi on is received, you must file an appeal within two days following the date of the conference. If you do not request a conference but file your appeal within 10 days of your advance notice of action to decrease or terminate your food stamps, your benefits may be continued until a hearing decision is reached. However, if the agency action is upheld, you will be required to repay benefits received during the appeal process.

If you wish to request a hearing, follow the instructions on the front of this form.

The person who conducts the hearing is someone from the State Department of Social Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call your service or eligibility worker immediately. If you need transportation, the local agency will provide it. You may bring a representative and/or witness to the hearing to help you tell your story. You eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

(1) examine all documents and records which are used at the hearing;

(2) present your case or have it presented by a lawyer or by another authorized representative;

(3) bring witnesses;

(4) establish pertinent facts and advance arguments; and

(5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 60 days of the date your appeal request is received by the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency; consequently, if you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you wi ll not be penalized for asking for a fair hearing. If you desire free legal advice you may contact your local legal aid office.

FOOD STAMP SANCTION NOTICE FOR NONCOMPLIANCE WITH A WORK REQUIREMENT

FORM NUMBER - 032-03-174

PURPOSE OF FORM - To inform households of reductions or terminations in their food stamp allotments due to sanctions for refusal or failure to comply with Employment Program requirements. The agency must also send this notice to notify households or individuals of the disqualification caused by quitting a job or reducing work without good cause.

USE OF FORM – The EW must complete this form after there is a decision to sanction an individual or household. NOTE: If there must be simultaneous sanctions in both TANF and food stamps for the household's failure to comply with a work requirement, the agency must complete a joint Advance Notice of Proposed Action (0320030018) instead of this form.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The original must be sent to the household. The copy must be retained in the Food Stamp case record.

INSTRUCTIONS FOR PREPARATION OF THE FORM

The agency must send this form for all employment program sanction situations, and findings of voluntary quit or work reduction, except for simultaneous TANF and food stamp sanctions as noted above. The agency must send the form even if the certification period is expiring or the household had previously been notified of adverse action for some other reason on another form.

Enter the appropriate identifying information at the top of the form.

Enter the name of the person who did not comply, and the requirement with which he/she did not comply. Obtain information from the Employment Service Worker for violations related to work registration other than failure to complete the registration form.

Check the appropriate entry to indicate if the entire household or if only an individual is to be sanctioned. List the months of the sanction, the reduction in benefits and the effective date, as appropriate.

Enter the date by which an appeal may be requested in order to continue benefits at the original amount. Enter the day that is 11 days after the date of mailing.

Complete the information at the bottom of the form.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
FOOD STAMP PROGRAM

NAME	SOCIAL SECURITY NUMBER
CASE NAME	CASE NUMBER

FOOD STAMP BENEFIT TRACKING SHEET

36 MONTH BENEFIT PERIOD _____ - _____
MMYY MMYY

MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5	MONTH 6	MONTH 7	MONTH 8	MONTH 9	MONTH 10	MONTH 11	MONTH 12
STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS

MONTH 13	MONTH 14	MONTH 15	MONTH 16	MONTH 17	MONTH 18	MONTH 19	MONTH 20	MONTH 21	MONTH 22	MONTH 23	MONTH 24
STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS

MONTH 25	MONTH 26	MONTH 27	MONTH 28	MONTH 29	MONTH 30	MONTH 31	MONTH 32	MONTH 33	MONTH 34	MONTH 35	MONTH 36
STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS	STATUS

STATUS CODES

PM: Month with prorated benefits.
Y1: Benefit received (1st 3 months).
Y2: Benefit received (2nd 3 months) Must be consecutive.
RE: Regained Eligibility.
N : No benefit received.
E1: Exempt. Working at least 20 hrs/wk.
E2: Exempt. Participating in an approved work program.
E3: Exempt. Minor child in home
E4: Exempt. Pregnant
E5: Exempt. Medically certified as unable to work.
E6: Exempt. Meets a work registration exemption.
E7: Exempt. Locality exempted.
E8: Exempt. Age.

FOOD STAMP BENEFIT TRACKING SHEET

FORM NUMBER - 032-03-920

PURPOSE OF FORM – **The agency may use this form** to track participation in the Food Stamp Program of each household member between the ages of 18 and 50, in order to limit participation to three months within a 36-month period or to accurately record exemptions to the Work Requirement accurately.

USE OF FORM - To be completed by the EW at certification and when changes are processed. **If the agency elects to use the form, the** EW must update the form retrospectively to record changes in exemptions and participation.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The form must be retained in the case record. The form or the information contained on the form must be shared with other Virginia localities when individuals move from one locality to another.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the individual member's name and case information at the top of the form. List the 36-month period beginning with the first month of participation. For each month, record a code for each month of participation.

Commonwealth of Virginia
Department of Social Services
NOTICE OF INTENTIONAL PROGRAM VIOLATION

Name and Address	Case Name
	Case Number
	Locality Date

An investigation of your _ Temporary Assistance for Needy Families (TANF) case, or _ Food Stamp case has recently been completed. We have reason to believe you intentionally violated a program rule because (may be continued on reverse):

We have the following evidence to support our case against you (may be continued on reverse):

Therefore, a request for an Administrative Disqualification Hearing for the purpose of proving the above allegation will be made. This hearing determines whether you or another person in your household should be disqualified from participation in the program(s) checked above.

You or your representative may look at the evidence at the local social services department by calling the number below to arrange a convenient time.

You have the right to an Administrative Disqualification Hearing prior to any action taken by the local Department of Social Services to disqualify you from receiving benefits. If you wish, you may waive your right to this hearing. By signing the attached waiver, you will be disqualified from receiving benefits for the period shown below whether or not you admit to the facts as presented.

Temporary Assistance for Needy Families (TANF)
_ 6 months, 1st violation _ 12 months, 2nd violation _ permanently, 3rd violation

If you are not receiving TANF benefits now, you will be subject to the above disqualification penalty whenever you apply for TANF and are found eligible for TANF benefits again.

Food Stamps
_ months, 1st violation _ months, 2nd violation _ permanently, 3rd violation
_ Other (Specify)

If you do not sign the attached waiver, an Administrative Disqualification Hearing will be held. If the hearing finds that you committed an Intentional Program Violation, you will be disqualified for the same period of time as shown above.

Neither signing the attached waiver nor holding the hearing shall prevent the State or Federal government from prosecuting you for an Intentional Program Violation in a criminal or civil court action, or from collecting the overpayment or overissuance. You have the right to remain silent concerning the allegations as anything said or signed by you could be used against you in a court of law.

Worker	Telephone	For Free Legal Advice Call

032-03-721/6

NOTICE OF INTENTIONAL PROGRAM VIOLATION

FORM NUMBER - 032-03-721 This form and instructions are **available online at www.localagency.dss.state.va.us/divisions/bp/forms.cgi.**

PURPOSE OF FORM - To advise a person that he/she is suspected of having committed an intentional program violation (IPV).

USE OF FORM – The worker must complete this form to advise a household that an IPV is suspected. The worker must send this form with the Waiver of Administrative Disqualification Hearing and the Administrative Disqualification Hearings pamphlet (032-01-961).

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The worker must send the original to the individual suspected of committing an IPV and keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form. Complete the form with appropriate information to note the program involved, the actions allegedly committed, the supporting evidence, and the length of the disqualification period. The back of the form may be used if additional space is needed for these explanations. Sign the form and complete the information at the bottom of the form.

Commonwealth of Virginia
Department of Social Services
WAIVER OF ADMINISTRATIVE DISQUALIFICATION HEARING

Name and Address	Case Name	
	Case Number	
	Locality	Date

The Notice of Intentional Program Violation told you the local agency suspects you intentionally violated a program rule in the _ Temporary Assistance for Needy Families (TANF) program, or _ Food Stamp Program. The Notice listed the evidence against you.

Amount of TANF overpayment $____ Amount of Food Stamp overissuance $

This form is a WAIVER of an administrative disqualification hearing.

IF YOU CHOOSE TO SIGN THIS WAIVER, you must indicate whether or not you admit to the facts as presented in the Notice of Intentional Program Violation. Please note: You do not have to admit to any of the allegations.

IF YOU ARE NOT THE APPLICANT, THAT PERSON MUST ALSO SIGN THIS WAIVER.

If you choose to sign this waiver, please return it by _____ to avoid scheduling a hearing. Please return the form to:

Agency Name and Address		
Worker	**Telephone**	**For Free Legal Advice Call**

WAIVER

Check one of the following statements:

_____ I admit to the facts as presented and understand that a disqualification penalty will be imposed and a reduction of benefits will occur if I sign this waiver.

_____ I do not admit that the facts presented are correct. However, I have chosen to sign this waiver and understand that a disqualification penalty and reduction of benefits will result.

Signature	**Date**
Signature of Applicant if Other Than You	**Date**

032-03-722/2

WAIVER OF ADMINISTRATIVE DISQUALIFICATION HEARING

FORM NUMBER - 032-03-722 This form and instructions are available online at www.localagency.dss.state.va.us/divisions/bp/forms.cgi.

PURPOSE OF FORM - To advise a household member suspected of having committed an intentional program violation (IPV) that the right to a hearing may be waived but the disqualification penalty will be imposed if the waiver is signed.

USE OF FORM – The local agency must complete the form and send it to determine if a waiver to the administrative disqualification hearing can be obtained before referring the case to the Hearing Authority. This form must be sent with the Notice of Intentional Program Violation.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The local agency must send the original to the individual suspected of committing an IPV and send a copy to **Fraud Management** if the waiver is signed. The agency must keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form. Enter the amount of the overpayment or overissuance for the program involved. Complete the form with the date by which the form must be returned if the waiver is to be activated. Enter a date that is 10 days after the mailing date.

If the right to the hearing is waived, the individual must complete the rest of the form and return it to the agency.

If a signed waiver is returned to the agency, a copy must be sent to **Fraud Management.**

Commonwealth of Virginia
Department of Social Services
REFERRAL FOR ADMINISTRATIVE DISQUALIFICATION HEARING

<table>
<tr><td>Case Name</td><td>Case Number</td><td>Locality</td></tr>
<tr><td>Member Suspected</td><td colspan="2" rowspan="2">TANF Violation (circle one) 1 2 3

Period of IPV

Amount of Overpayment $</td></tr>
<tr><td rowspan="2">Address (include city, state, zip)</td></tr>
<tr><td colspan="2">Food Stamps Violation (circle one) 1 2 3

Period of IPV

Amount of Overissuance $</td></tr>
</table>

The suspected household member is alleged to have committed the following act(s) of intentional program violation:

We have the following evidence to support our case:

Copies of evidence to be presented at the hearing to prove the allegation are attached, including: 1) Verification or documents to support the charge; 2) Any applications for Temporary Assistance for Needy Families or Food Stamps signed by the accused during the time in which the intentional program violation allegedly occurred.

Information in this referral is provided with the knowledge it will be used in reaching a decision on the allegations made in this referral, and will be made available to the accused individual or representative.

Submitted by	Title	Telephone	Date

032-03-725/3

REFERRAL FOR ADMINISTRATIVE DISQUALIFICATION HEARING

FORM NUMBER - 032-03-725 This form and instructions are available online at **www.localagency.dss.state.va.us/divisions/bp/forms.cgi**.

PURPOSE OF FORM - To refer cases to the State Hearing Authority where an individual is suspected of having committed an intentional program violation.

USE OF FORM – The local agency worker must complete the form to provide information needed by the State Hearing Authority in order to initiate an administrative disqualification hearing. Mail the referral to:

Virginia Department of Social Services
Hearings and Legal Services Manager
7 North Eighth Street
Richmond, VA 23219-3301

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The local agency must send the original and one copy to the Hearings Manager and keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the information requested at the top of the form. The Period of Intentional Program Violation (IPV) is the span of time over which the IPV occurred. This will often coincide with the dates over which a claim was established.

The "Amount of Overissuance" is the total amount of the claim which relates to the IPV. If the IPV was due to an act which did not result in an overissuance, for example, using food stamps to pay rent, or misrepresenting the household's income on an application that was subsequently denied, indicate "0" overissuance in this block.

Explain the intentional act alleged and the evidence the agency has to support its claim. Evidence listed here is to be made available to the individual and will be presented at the hearing. Confidential or other information restricted from the household cannot be the basis of the evidence to support the accusation of an IPV.

The agency director/superintendent or designee must sign the form.

Commonwealth of Virginia
Department of Social Services
ADVANCE NOTICE OF ADMINISTRATIVE DISQUALIFICATION HEARING

Name and Address	Case Name	
	Case Number	
	Locality	Date

The local social service department has recently completed an investigation of you_____ Temporary Assistance to Needy Families (TANF) case, or _____Food Stamp case.

The department believes you committed an intentional violation of a program rule because (continue on reverse, if necessary):

The department has the following evidence to support the case against you (continue on reverse, if necessary):

You or your representative may look at this evidence at the local social service department by calling your local worker to arrange a convenient time.

An Administrative Disqualification Hearing has been scheduled to examine the facts of your case. The hearing will be held at:

Time	Place
Date	

If the hearing officer finds you intentionally violated a program rule, you will be disqualified from receiving benefits for the period shown below (the items checked apply to you):

Temporary Assistance for Needy Families (TANF)

_____ 6 months, 1st violation _____ 12 months, 2nd violation _____permanently, 3rd violation

If you are not receiving TANF benefits now, you will be subject to the above disqualification penalty whenever you apply for TANF and are found eligible for TANF benefits again.

_____months, 1st violation _____months, 2nd violation _____ permanently, 3rd violation
_____Other (specify)_____

It is important that you or your representative be at the hearing. Otherwise, a decision will be based solely on information provided by the local social service department. If you are unable to attend the scheduled hearing, you must contact the local social service department at least 10 days in advance of the hearing date. If you or your representative fail to appear at a scheduled hearing, you must contact the local the local social service department within 10 days after the date of the hearing and present good reason for your failure to appear in order to receive a new hearing. An explanation of the steps involved in a hearing is enclosed.

(continued on next page)

ADVANCE NOTICE OF ADMINISTRATIVE DISQUALIFICATION HEARING

Even though this hearing is scheduled, this does not prevent the State or Federal Government from prosecuting you for an intentional violation of a program rule in a court of law or from collecting the overpayment or overissuance. If you have any questions or need the name and phone number of someone who can give you free legal advice, call the local social service office at: _____

Hearing Officer	Phone Number

(Continuation of explanations from page 1, if necessary)

YOU HAVE THE RIGHT TO:

- Look at the evidence that will be used at the hearing both before and during the hearing. Please call the local social service department if you wish to look at the evidence before the hearing. The department will provide a free copy of the portions of your case file that relate to the hearing upon request.
- Present your own case or have someone present your case for you, such as a lawyer, friend, relative, or community worker.
- Bring your own witnesses.
- Argue your case freely.
- Question or deny any evidence or statements made against you.
- Bring any evidence you may have that would support your case.
- Remain silent concerning the charge(s) against you.

ADVANCE NOTICE OF ADMINISTRATIVE DISQUALIFICATION HEARING

FORM NUMBER - 032-03-724 This form and instructions are **available online at www.localagency.dss.state.va.us/divisions/bp/forms.cgi.**

PURPOSE OF FORM - To schedule an administrative disqualification hearing (ADH).

USE OF FORM – The hearing officer must complete the form to provide an individual with a notice in advance of an ADH. The form must be sent by first class mail or certified mail with return receipt requested, or may be provided by any other reliable method. The ADH pamphlet must be sent to the individual with the advance notice.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The hearing officer must send the original to the individual alleged to have committed an IPV and a copy to the local agency. The hearing officer must keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form. Information provided on the referral for the ADH will be used as the basis for the hearing.

Complete the form with the date, time and location of the hearing. Note the disqualification period for the IPV. Include other information as needed to complete the form.

Commonwealth of Virginia
Department of Social Services
ADMINISTRATIVE DISQUALIFICATION HEARING DECISION

Name and Address	Case Name
	Case Number
	Locality

On the basis of evidence presented at the Administrative Disqualification Hearing held on _____, it has been determined that you:

___ DID NOT COMMIT an intentional violation of a Temporary Assistance for Needy Families (TANF) or Food Stamp program rule.
___ DID COMMIT an intentional violation of a Temporary Assistance for Needy Families (TANF) or Food Stamp program rule.

If you did commit an intentional program violation, the local agency will disqualify you from receiving benefits for the time shown below:

Temporary Assistance for Needy Families (TANF)
_____ 6 months, 1st violation ____12 months, 2nd violation ____ permanently, 3rd violation

If you are not receiving TANF benefits now, the period of disqualification will be postponed until such time as you apply for TANF benefits and are found eligible again.

Food Stamps
____ months, 1st violation ____ months, 2nd violation ____permanently, 3rd violation
____ Other (Specify)

The local agency is responsible for notifying you of the date the disqualification will take effect. Also, the local agency is responsible for notifying you of the effect the disqualification will have on the benefits to be received by any remaining household members.

This hearing decision does not prevent the local agency, State or Federal government from asking you to pay back the amount of any extra Temporary Assistance for Needy Families (TANF) benefits or Food Stamp benefits your household was not eligible to receive. The local agency is responsible for sending you a letter requesting repayment.

If you are not satisfied with the hearing decision, you can ask for a review of this decision by the Commissioner, Virginia Department of Social Services by sending a written request within 10 days of receipt of this notice to:

Virginia Department of Social Services
Hearings and Legal Services Manager
7 North Eighth Street
Richmond, VA 23219-3301

Hearing Officer	Date

032-03-723/8

ADMINISTRATIVE DISQUALIFICATION HEARING DECISION

FORM NUMBER - 032-03-723 (This form and instructions are **available online at www.localagency.dss.state.va.us/divisions/bp/forms.cgi.**

PURPOSE OF FORM - To advise the household member suspected of an intentional program violation (IPV) of the outcome of the Administrative Disqualification Hearing (ADH).

USE OF FORM – The hearing officer must complete the form to include the decision rendered.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The hearing officer must send the original to the household member and send a copy to the local agency. The hearings officer must keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information requested at the top of the form. Complete the form showing the date of the hearing and note whether an IPV was committed. If an IPV was determined, note the disqualification period for the program involved.

Commonwealth of Virginia
Department of Social Services
NOTICE OF DISQUALIFICATION FOR INTENTIONAL PROGRAM VIOLATION

Name and Address	Case Name	
	Case Number	
	Locality	Date

This notice is to inform you of the disqualification of a person from the ___ Temporary Assistance for Needy Families (TANF) program, or _ Food Stamp Program.

_____ has been disqualified for the amount of time shown:

TANF ___ 6 months ___ 12 months ___ Permanently

Food Stamps __ _ months __ _ months ___ Permanently ___ Other (specify)

The reason for the disqualification is shown below:

____ Court of appropriate jurisdiction found the person guilty of committing an intentional program violation of ___ TANF or ___ Food Stamp policy.

___ An Administrative Disqualification Hearing found the person guilty of committing an intentional program violation of ___ TANF or ___ Food Stamp policy.

___ The person waived his or her right to an Administrative Disqualification Hearing. The person had been informed that the disqualification penalty would be imposed.

The disqualification period will begin:

___ From the TANF program, effective _____.

The TANF payment will change from $ _____ to $ _____.

___ If this blank is checked, the disqualification will begin when the person next applies for and is found eligible for TANF.

___ From the Food Stamp program, effective _____.

The Food Stamp allotment will change from $ _____ to $ _____.

Worker	Telephone	For Free Legal Advice Call

032-03-052/11

NOTICE OF DISQUALIFICATION FOR INTENTIONAL PROGRAM VIOLATION

FORM NUMBER - 032-03-052 (This form and instructions are **available online at www.localagency.dss.state.va.us/divisions/bp/forms.cgi.**

PURPOSE OF FORM - To advise the household of a disqualification due to an intentional program violation.

USE OF FORM – The local agency worker must send this form to advise the household of the length, reason and starting date of a disqualification.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The local agency worker must send the original to the household and file a copy in the case record.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the form with information appropriate for the case and for the program involved. Enter the name of the individual who is to be disqualified.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
FOOD STAMP PROGRAM
NOTICE OF ACTION AND EXPIRATION

THIS IS TO INFORM YOU OF ACTION TAKEN ON YOUR FOOD STAMP APPLICATION OR CASE

CASE NUMBER
DATE
COUNTY/CITY

SECTION 1. ACTION ON APPLICATION DATED _____

Approved for following months _____

Amount first month $_____ Months covered_____ Amount for following months$_____

You selected _____as Head of Household. If all adult members do not agree, contact your worker within 10 days.

YOU MUST REPORT WITHIN 10 DAYS REQUIRED CHANGES IN THE PERSON IN YOUR HOUSEHOLD AND IN YOUR FINANCIAL SITUATION. If necessary, you may call collect.

Children approved for food stamp benefits and attending public school may be eligible for free meals. Call your school for more information.

Food stamp or an ATP card not received in the mail or destroyed after receipt may be replaced if the loss is reported right away.

If you do not agree with the action we have taken or the amount of food stamps you are receiving, you can have a fair hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake, and a hearing officer will decide if you are right. To request a fair hearing, you may call me at the number below or write to the Virginia Department of Social Services, Attention: Manager, Appeals and Fair Hearings, 730 East Broad Street, Richmond, Virginia 23219-1849. You may also request a fair hearing by calling toll free 1-800-552-3431. You must request your fair hearing within the next 90 days. If you appeal the action on your case before _____assistance may continue. However, if assistance is continued, you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action. For additional information about appeals and fair hearings, please see the back of this notice.

SECTION 2. ACTION REQUIRED TO RECEIVE UNINTERUPTED BENEFITS

Your food stamp certification will end on _____

In order to receive uninterrupted benefits following the end of your current certification, you must complete a new application.

by_____ and be found eligible based on the information given on this application. You may request an application to complete yourself or to be completed by anyone you choose, or we will be happy to assist you to complete the application. We can only begin processing your request for continued certification upon receipt of an application form having at least your name, address and signature. If you fail to complete an application by the date indicated above, you cannot be assured of continued participation without interruption.

We have arranged an appointment for an interview on:_____
if you miss this or any interview scheduled by the local social services agency for your food stamp application, it will be your responsibility to reschedule it. If you unable to come to the agency for an interview and you are unable to appoint an authorized representative to come for you, please let us know. Under certain circumstances, an office interview may be waived and arrangements made for an out-of-office or telephone interview. It will also be necessary for you to provide your eligibility worker with proof of your income and expenses if requested in order to receive uninterrupted benefits.

If all members of your household are now receiving Supplemental Security Income (SSI) or plan to apply for SSI, you may reapply for food stamps at the social security office instead of filing your application at the local social services agency. The social security office will send your application to the social services agency for processing. If you choose to do this, the social security office must also receive your application by the date indicated above.

Worker	Telephone Number	For Free Legal Advice Call

APPEALS AND FAIR HEARINGS

A fair haring provides you opportunity to review the way a local social services agency has handled your situation concerning your stated need for food stamps. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services.

In addition to filing an appeal, you have the right to request a conference with your local social services agency, at which time the agency must give you an explanation of its proposed action. You must also be given the opportunity to present any information on which your disagreement with the agency's proposed action is based. At such a conference, you have the right to have your story presented by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receipt of your advance notice of proposed action to decrease or terminate your food stamps, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the local social services agency's action following the conference, and you want to request that your food stamps be continued as usual until a hearing decision is received, you must file an appeal within two days following the date of the conference. If you do not request a conference but file your appeal within 10 days of your advance notice of action to decrease or terminate your food stamps, your benefits may be continued until a hearing decision is reached. However, if the agency action is upheld, you will be required to repay assistance received during the appeal process.

If you request an appeal concerning your food stamps, the local social services agency must offer you a conference after your appeal is filed.

If you wish to request a hearing, follow the instructions on the front of this form.

The person who conducts the hearing is someone from the State Department of Social Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call your service or eligibility worker immediately. If you need transportation, the local agency will provide it. You must bring a representative and/or witness to the hearing to help you tell your story. Your service or eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

(1) examine all documents and records which are used at the hearing;

(2) present your case or have it presented by a lawyer or by another authorized representative;

(3) bring witnesses;

(4) establish pertinent facts and advance arguments; and

(5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 60 days of the date your appeal request is received by the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency, consequently, if you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice you may contact your local legal aid office.

NOTICE OF ACTION AND EXPIRATION

FORM NUMBER - 032-03-460

PURPOSE OF FORM - To notify applying households of the approval of the application and the end of the certification period so that households will have the opportunity to file a timely application for recertification.

USE OF FORM - To be sent by the local agency to advise the household of the approval of the application, the certification period, amount of benefits and the date by which a recertification application must be filed.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The original is to be mailed to the household. The copy is to be filed in the case record.

INSTRUCTIONS FOR PREPARATION - The form may be used in place of the Notice of Action and the Notice of Expiration. If used, the Notice of Action And Expiration must be completed by the eligibility worker and provided to the applicant upon the approval of the application. This form is appropriate only for those households assigned a one-month certification period or those approved in the last month of eligibility.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

FIPS

ADAPT VERIFICATION FORM

Case Name:	ADAPT Case #: Legacy Case #:	Residence Verification:
Programs:	Application/Renewal Date:	Identity Verification:
Authorized Representative/Identity Verification:		Interview Date: Face to Face Interview: ❑ Yes ❑ No If No. Reason:

1. Resources: **2. Vehicles:**

Per#	Type/Code	Verification	Per #	Identifier	Verification
					DMV ❑ Match ❑ No Match Date _____

3. Earned Income/Unearned Income:

Per#	Type/Code	Verification

VEC ❑ Match ❑ No Match Date _____ SVES ❑ Match ❑ No Match Date _____ APECS ❑ Match ❑ No Match Date ____

4. Shelter Expenses: **5. Day Care/Medical/Support Expenses:**

Per#	Type	Verification	Per #	Type	Verification

UTILITY STANDARD ❑ Y ❑ N ❑ 1-3 ❑ 4+ PHONE STANDARD ❑ Y ❑ N HOMELESS STANDARD ❑ Y ❑ N

REASON FOR ENTITLEMENT TO STANDARD

6. Divisionary Assistance Program

Documentation of Circumstances:	Amount/Type Emergency Verification **Remember:** Enter Sanction Period (POI) in ADAPT

7. Other (*Check any items that require verification and document your verification in the space below)*

❑ Deprivation ❑ Living with Specified Relative ❑ Immunizations ❑ Truancy ❑ Excluded Persons/Reason ❑ FS Work Requirement Exemption ❑ FSET/ESP/VIEW Registration or Participation ❑ Voluntary Quit ❑ Sanction/Penalty ❑ Resource/Income Transfer ❑ Disability/Aged ❑ Health Insurance ❑ HIPP/Medical Questionnaire ❑ Medicaid Assignment of Rights (Indicate Person(s) Ineligible) ❑ Pregnancy/Conception Date Estimated Due Date ❑ Other Specify:_____ _____	

8. Good Cause Claimed:

❑ DCSE ❑ Yes ❑ No ❑ FAMIS Dropped Insurance ❑ Yes ❑ No	Documentation: _____ Good Cause: ❑ Exists ❑ Does Not Exist

IF ALL PROGRAMS APPLIED FOR ARE ON ADAPT, PLEASE GO TO PAGE 4.

Evaluation of Eligibility

9. Programs: ❑ Medicaid ❑ GR ❑ AG ❑ SLH ❑ TANF-EA ❑ RRP ❑ FAMIS

10. Case Number	**11. Retroactive Medicaid Determination:**
	Retroactive Period From: to: Service in past 3 months: ❑ Y Date ❑ N

12. Institutional Status:

❑ NF	❑ CBC	❑ ACR/AFC	Date Entered	ACR/AFC Rate
DMAS-96	❑ Y	❑ N	SAR ❑ Y ❑ N	Community Spouse? ❑ Y ❑ N

13. Income:

Type	Countable Y/N	Calculations/Comments:	Amount
INCOME LIMIT:		TOTAL COUNTABLE INCOME:	

14. Resources

Type	Countable Y/N	Calculations/Comments:	Amount
RESOURCE LIMIT:		TOTAL COUNTABLE INCOME:	

15. Spend-down Calculation:

Period	Person(s)	Countable Income	Income Limit	Excess Income

16. Medicaid Covered Group:

17. State/Local Hospitalization:

Person(s)	Service Date(s)	Provider(s)	Applied within 30 days? Y/N

18. General Relief Maintenance:

Period of Unemployment:	Applied for SSI? ❑ Y	Date:	❑ N
SSI Decision Appealed? ❑Y ❑ N	Release of SSI Check Signed? ❑ Y	Date:	❑ N
❑ Full Standard ❑ Modified Standard	Reason for Modified Standard:		

19. Emergency Assistance:

Date and Reason for Emergency:		
Assistance Previously Received: ❑Y ❑ N	Dates and Amounts Received:	

20. Comments:

21. Disposition: Date Given: Food Stamp Hotline Info _____ Benefit Programs Booklet _____ Medicaid Handbook _____

Food Stamps	TANF	Medicaid	FA\MIS	TANF-EA/GR/AG//SLH/RRP
Certification Period: to				

22. Signatures:

EW Signature	Date	Supervisor Signature	Date

PARTIAL REVIEWS AND CHANGES

Program	Action Date	Effective Date	Reason for review, methods and dates of verification	Worker's Signature and Date (Supervisor's Signature/Date)

ADAPT VERIFICATION FORM

FORM NUMBER - 032-03-366

PURPOSE OF FORM - To be used with the Permanent Verification Log to document methods and dates of verification of eligibility factors in Food Stamps and TANF cases. In addition, this form is used to document verification and determine eligibility for Medicaid, General Relief, SLH, TANF-EA, Refugee Assistance, and Auxiliary Grants when the evaluation is being completed at the same time as TANF or Food Stamps. When eligibility for other programs is being evaluated separately from the Food Stamp Program or TANF, the Evaluation of Eligibility form (032-03-823) must be completed. Documentation must be in sufficient detail to permit a supervisor, Quality Control, fraud investigator, or any other person reviewing the case record and information in ADAPT to determine the reasonableness and accuracy of the determination of eligibility.

USE OF FORM - The form must be completed at application and renewal for all programs for which the applicant/recipient is applying or receiving assistance. The form is also used to document and verify interim changes and determine continued eligibility as appropriate.

DISPOSITION OF FORM - The form must be retained in the case record with the appropriate ADAPT Request for Assistance and Statement of Facts OR application.

INSTRUCTIONS FOR PREPARATION OF FORM - When completing this form, it is not necessary to restate information if it is attached. Reference must be made to any information attached to the form.

CASE INFORMATION

Enter identifying case and application information, as appropriate.

- **Residence Verification**: Verify residence, as required by policy.
- **Identity Verification**: Verify identity, as required by policy.
- **Authorized Representative/Identity Verification**: Enter the authorized representative's name and verify identity, as required by policy.
- **Interview Date**: Enter the date the applicant/recipient or authorized representative is interviewed. Indicate whether this is a face-to-face interview, and if not, the reason.

1. Resources: For each resource verified, enter the ADAPT person number, the type of resource or ADAPT resource code (e.g., bank accounts, real property, business or farming equipment) and verification (date, method, and source of verification).

2. Vehicles: For each vehicle, enter the ADAPT person number, the vehicle identifier used in ADAPT, and verification (date, method, and source of verification). Complete a DMV inquiry and indicate whether a match was found, the date of the DMV records check, and attach the match. Document resolution of any discrepancies. If matches must be completed on more than one person, use the Comments section for the additional persons. If no change has occurred since the previous match, the agency may indicate "no change" and is not required to print the match information again.

3. Earned and Unearned Income: For each source of income verified, enter the ADAPT person number, the type of income or the ADAPT income code, and verification (date, method, and source of verification, and explanation as to the pay verification used, if applicable). Include in-kind income and vendor payments.

Indicate when APECS, VEC, or SVES matches were checked, and attach any matches. Document resolution of any discrepancies. If matches must be completed on more than one person, use the Comments section for the additional persons. If no change has occurred since the previous match, the agency may indicate "no change" and is not required to print the match information again.

4. Shelter Expenses: Enter the ADAPT person number, the type of expense, and the date, method and source of verification.

5. Day Care/Medical/Support Expenses: For each expense verified, enter the ADAPT person number, the type (day care, medical expense, or support), and verification (date, method, and source of verification).

6. Diversionary Assistance Program: Enter the date, method, and source of the verification received documenting the need(s) for diversionary assistance, the type of emergency, and the amount needed to resolve the emergency.

7. Other Documentation: Check the appropriate items and enter the date, method, and source of verification. If "Other" is checked, specify the requirement being documented or questionable information being resolved, e.g., separate household status.

8. Good Cause Claimed: Check the type of good cause claim applicable to the program(s) evaluated. Indicate whether good cause exists and explain the basis for the decision.

NOTE: IF ALL PROGRAMS APPLIED FOR ARE ON ADAPT, PROCEED TO ITEMS 20 -22, AS APPLICABLE, otherwise complete #9-19.

9. -12 Complete as appropriate.

13. Income: Enter the type of income, whether it is countable, any calculations/explanations, and the amount of countable income from each source. Enter the appropriate income limit and the total countable income.

14. Resources: Enter the type of resource, whether it is countable, any calculations/explanations, and the amount of each countable resource. Enter the appropriate resource limit and the total countable resources.

15. Spend-down Calculation: Complete, as appropriate.

16. Medicaid Covered Group: Complete as appropriate. Specify the covered group from Volume XIII, Chapter M03. If the applicant/recipient does not meet a covered group, document the basis for the decision.

17.-19 Complete as appropriate.

20. Comments: Enter any additional information pertinent to the case not stated elsewhere, including calculations, such as Medicaid budget units.

21. Disposition: Enter the disposition for applicable programs. Enter the certification period for the Food Stamp case.

22. Signatures: The Eligibility Worker must sign and date the form. If a supervisory review is done, the supervisor must sign and date the form also.

PARTIAL REVIEWS AND CHANGES - Complete, as appropriate, for changes that occur between renewals to determine the effect on eligibility.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

NOTICE OF TRANSFER

Case Name:_____

Case Number:_____

Agency:_____

Date:_____

Your ___ Food Stamp, ___ Medicaid, or ___ Temporary Assistance for Needy Families (TANF) case(s) was transferred to _____ because of your recent move to that city or county. A representative of that agency will contact you to review your case.

Your benefits for these programs will continue without interruption.

Your TANF grant will change from $_____ to $_____ because of your move to the new city/county.

☐ If the amount of your food stamp or TANF benefits went up because of a reported change in income, expenses, or the number of people in your household, you will need to show proof of the change. You will need to give this information to the new agency within 10 days or the amount of your food stamps or TANF will go back to $_____ without additional notice.

You must report changes or file applications with the new agency. The address and telephone number of the new agency is:

_____

_____

_____

_____

Telephone _____

_____ _____
(Worker Signature) (Telephone Number)

REMINDER: Please keep your Cardinal Card if you receive food stamps and your Medicaid card if you receive Medicaid. You do not need a new card just because of your move.

032-03-658 (7/04)

APPEALS AND FAIR HEARINGS

If you do not agree with the action we are proposing or the amount of benefits you are receiving, you may have a fair hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake and a hearing officer will decide if you are right. A hearing gives you a chance to review the way a local social services agency handled your situation about your need for TANF or food stamps. The hearing is a private, informal meeting at the local social services agency with you and anyone you want to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearings officer. The hearing officer is the official representative of the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you want free legal advice, you may contact your local legal aid office.

How to File an Appeal

- Send a written request to the **Virginia Department of Social Services, Attention: Hearing and Legal Services Manager, 7 North Eighth Street, Richmond, Virginia 23219-3301**
- Call me at the number listed on the front
- Call **1-800-552-3431**

When to Appeal

- Within the next 30 days for TANF and within the next 90 days for food stamps.
- Within 10 days of the date on this form to get the food stamps continued.*
- Before the effective date of the change to get the TANF benefits continued.*

*Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

Local Agency Conference

In addition to filing an appeal, you may have a conference with your local social services agency. During the conference, the agency must explain its proposed action. You will have the chance to present any information where you disagree with the agency's proposed action. You may present your story by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receiving of your notice to decrease or end your TANF or food stamps benefits, the proposed action will not take place until after there is a decision made for the conference.

If the conference does not satisfy you and you want to continue to receive your benefits until there is a hearing decision, you must file an appeal for TANF benefits within two days following the date of the conference and within 10 days of the conference date for food stamps. If you do not ask for a conference but you file an appeal within 10 days of the notice of action to reduce, suspend, or terminate your TANF or food stamps, you may continue to receive benefits until there is a hearing decision. If you appeal the proposed action on your TANF case before the reduction, suspension or termination effective date, you may also receive continued coverage. Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

Hearing Process and Decision

The hearing officer will notify you of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your eligibility worker immediately. If you need transportation, the local agency will provide it.

At the hearing, you and/or your representative will have the opportunity to:

- Examine all documents and records used at the hearing;
- Present your case or have it presented by a lawyer or by another authorized representative;
- Bring witnesses;
- Establish pertinent facts and advance arguments; and
- Question or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

The hearings officer will base the decision only on the evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In this event, you and the local social services agency would have the opportunity to question or refute this additional information.

You will get the hearings officer's decision in writing on your appeal within 60 days of the date the State Department of Social Services receives your appeal request.

Notice of Transfer

FORM NUMBER - 032-03-658

PURPOSE AND USE OF FORM - To advise a household that responsibility for a case has been transferred from one locality to another and to provide the contact information of the new agency.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The local agency worker must complete the form and mail it to the household when a case record is transferred to another locality.

INSTRUCTIONS FOR PREPARATION OF FORM –

Complete the form with identifying information of the case and with the telephone number and address of the local social services agency to which the case has been transferred. **Mark the section to note** if the household is required to provide verifications that affect the benefit amount to the new agency. **Identify the information needed from the household on the Notice of Action or checklist and on the Case Record Transfer Form.**

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

CASE RECORD TRANSFER FORM

TO DEPARTMENT OF SOCIAL SERVICES

_____
COUNTY/CITY

_____
ADDRESS

FROM DEPARTMENT OF SOCIAL SERVICES

_____
COUNTY/CITY

_____
ADDRESS

I. TRANSFERRING LOCALITY CASE INFORMATION

CASE NAME: _____ CASE NUMBER: _____

MOVED TO YOUR LOCALITY ON _____ AND IS RESIDING AT _____

_____

UNIT MEMBERS _____

TYPE OF ASSISTANCE:

☐ TANF VIEW CASE ☐ TANF NON-VIEW CASE ☐ REFUGEE CASH ASSISTANCE ☐ OTHER _____

AMOUNT OF PAYMENT _____ LAST PAYMENT MONTH _____

☐ VERIFICATION OF _____ NEEDED BEFORE ISSUANCE OF _____ BENEFITS

☐ FOOD STAMPS CERTIFICATION PERIOD END DATE ____/____/____

☐ VERIFICATION OF _____ NEEDED BEFORE ISSUANCE OF _____ BENEFITS

☐ PENDING MEDICAID ☐ RECEIVING MEDICAID ☐ RECEIVING REFUGEE MEDICAL ASSISTANCE

☐ RECEIVING FAMIS (APPLICATION, EVALUATION, INCOME VERIFICATION, AND NOTICE OF ACTION ATTACHED)

ADDITIONAL REMARKS:

SIGNATURE (AGENCY REPRESENTATIVE) _____ DATE: _____

PRINTED NAME _____ TITLE: _____

II. CONFIRMATION OF RECEIPT & DISPOSITION

CASE RECORD WAS RECEIVED _____ DETERMINED: ☐ ELIGIBLE ☐ INELIGIBLE

EFFECTIVE _____ FOR _____
DATE TYPES OF ASSISTANCE

ADDITIONAL REMARKS:

SIGNATURE (AGENCY REPRESENTATIVE) _____ DATE: _____

PRINTED NAME _____ TITLE: _____

032-03-227/9 (7/04)

Case Record Transfer Form

FORM NUMBER - 032-03-227

PURPOSE AND USE OF FORM - To communicate between local departments of social services when transferring responsibility for a case for program benefits from one agency to another. The form also serves as confirmation to acknowledge receipt of the case record.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The local agency worker in the transferring agency must complete the names and addresses of the affected agencies and appropriate parts Section I of the form to address the types of assistance affected. The worker must prepare the case record for transfer to the new locality and send two copies of the form and case record to the receiving agency. The transferring agency must keep a copy of the completed form.

INSTRUCTIONS FOR PREPARATION OF FORM -

Complete the form with identifying information of the case and with the names and addresses of the agency from which the case is being transferred and the agency to which the case is being transferred. Complete Section I to identify the types of assistance and benefit amounts for the household. Add additional comments as needed. A representative of the transferring agency must sign the form.

A representative of the receiving local agency must complete Section II of the form to acknowledge the receipt of the case record. The agency must send copy of the completed form to the agency from which the case was transferred and keep a copy of the form.